Pathway Partnership Programme
Impact Report 2025-26

Better care
Better outcomes
Better value

September 2026

Edited by Alex Bax and Dr Chris Sargeant

Pathway
Homeless & Inclusion Health

Acknowledgements

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About Us

Pathway is the UK's leading homeless and inclusion health charity. We work with and alongside the NHS to improve care quality and outcomes for people experiencing homelessness and other inclusion health groups. In 2021 Pathway joined the Crisis group to create a strategic alliance to maximise our joint impact.

If you would like to talk to someone about partnering with us or joining the Pathway Partnership Programme, please contact paul.hamlin@pathway.org.uk.

If you would like information about our wider work on homeless and inclusion health, please visit our website at **www.pathway.org.uk.**

You can join the Faculty for Homeless and Inclusion Health and receive regular email updates about our work and about inclusion health in the NHS by signing up at **www.pathway.org.uk/the-faculty/support-the-faculty/**

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Pathway
Homeless & Inclusion Health

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NHS
Ashley Greaves
Bevan

Foreword

I am one of the statistics about homelessness that you'll read about in this report.

Years of trauma, homelessness, addiction and repeated hospital discharges that led straight back to the streets, had left me broken. I'd stopped believing things could ever get better.

That changed on the 25th of March 2024. Fighting for my life in St George's hospital after a violent attack that left me with life changing injuries, the St George's Homeless Inclusion Team came to my bedside.

They treated me with dignity, compassion and respect. There was no judgement, no stigma. At a time when I felt invisible, they saw me as a person. Their support went far beyond my hospital bed and my immediate medical needs; they helped me access housing, healthcare and ongoing support when I was discharged.

Today, I'm off the street and no longer a frequent patient in A&E. The team helped me break the cycle of homelessness, hospital admissions and returning to the streets.

I'm now in recovery, volunteering, mentoring others and using my experience to help improve services for people facing homelessness. People like me.

I'm living proof of the difference teams across the Pathway Partnership Programme make.

As you read this report, I ask you to remember that behind every number, every outcome and every statistic is a person like me.

Matthew Quartey

St George's Homelessness Inclusion Team
Pathway Lived Experience Volunteer

The Strategic Case: Why Pathway matters now

"Delivering better outcomes for patients. Reducing pressure on the NHS. Creating value for commissioners."

The Pathway Partnership Programme delivers a proven, evidence-based intervention that improves outcomes for patients, reduces pressure on hospitals and delivers measurable value for the NHS.

Homelessness is a growing challenge for the NHS

People experiencing homelessness face some of the poorest health outcomes in Britain. Mortality rates are around ten times higher than those of the general population, with significantly higher levels of physical illness, mental ill health and substance dependence[i].

Barriers to accessing timely healthcare mean many people only reach hospital when their health has deteriorated to crisis point. As a result, hospitals are increasingly caring for patients with multiple, complex needs that extend well beyond clinical treatment alone.

Without specialist support, patients experiencing homelessness are more likely to:

- remain in hospital longer
- experience delayed discharge
- be discharged to unsafe accommodation or to rough sleeping
- return repeatedly to A&E
- require emergency readmission.

The consequences are felt across the whole system: increased pressure on beds, avoidable demand on urgent and emergency care, poorer patient outcomes and wasted resources.

For NHS organisations, this creates a predictable pattern:

Homelessness

↓

Complex health needs

↓

Increased hospital demand

↓

Higher NHS costs

A unique opportunity to improve outcomes

A hospital admission is a critical opportunity to break this cycle. It is often the first point at which health, housing and wider social needs can be identified together, allowing coordinated intervention before problems escalate further.

When hospitals combine clinical care with specialist housing and community support, they can:

- **improve recovery**
- **enable safer discharge and help end homelessness**
- **reduce avoidable readmissions**
- **strengthen long-term engagement with healthcare**
- **reduce future demand on NHS services.**

A hospital admission can therefore become much more than treatment for an immediate acute health crisis. It can become the starting point for better health, housing stability and lasting recovery.

The Pathway Partnership Programme

The Pathway Partnership Programme helps NHS organisations turn this opportunity into measurable results. Combining clinical expertise, lived experience and over 15 years' of evidence-based practice, Pathway works in partnership with NHS organisations to improve care for people experiencing homelessness while strengthening health systems.

A trusted expert partner operating in complex healthcare environments, Pathway delivers a structured, tailored, and cost-effective programme that supports organisations to address health inequalities and create sustainable system change.

The programme is flexible and offers commissioners three discrete but complementary services:

Inclusion Health Needs Assessments – understanding local need

Pathway Hospital Teams – delivering specialist services

Consultancy Support – improving systems

The Partnership Programme helps commissioners and providers to:

Improve patient outcomes
Supporting people into healthcare, housing and community services that improve recovery, reduce exclusion and prevent repeat crises.

Reduce pressure on hospitals
Reducing avoidable bed days, delayed discharge, emergency attendances and readmissions while improving patient flow.

Deliver national NHS priorities
Providing a practical mechanism for delivering NICE guidance, tackling health inequalities and supporting inclusion health priorities.

Why commissioners should act now

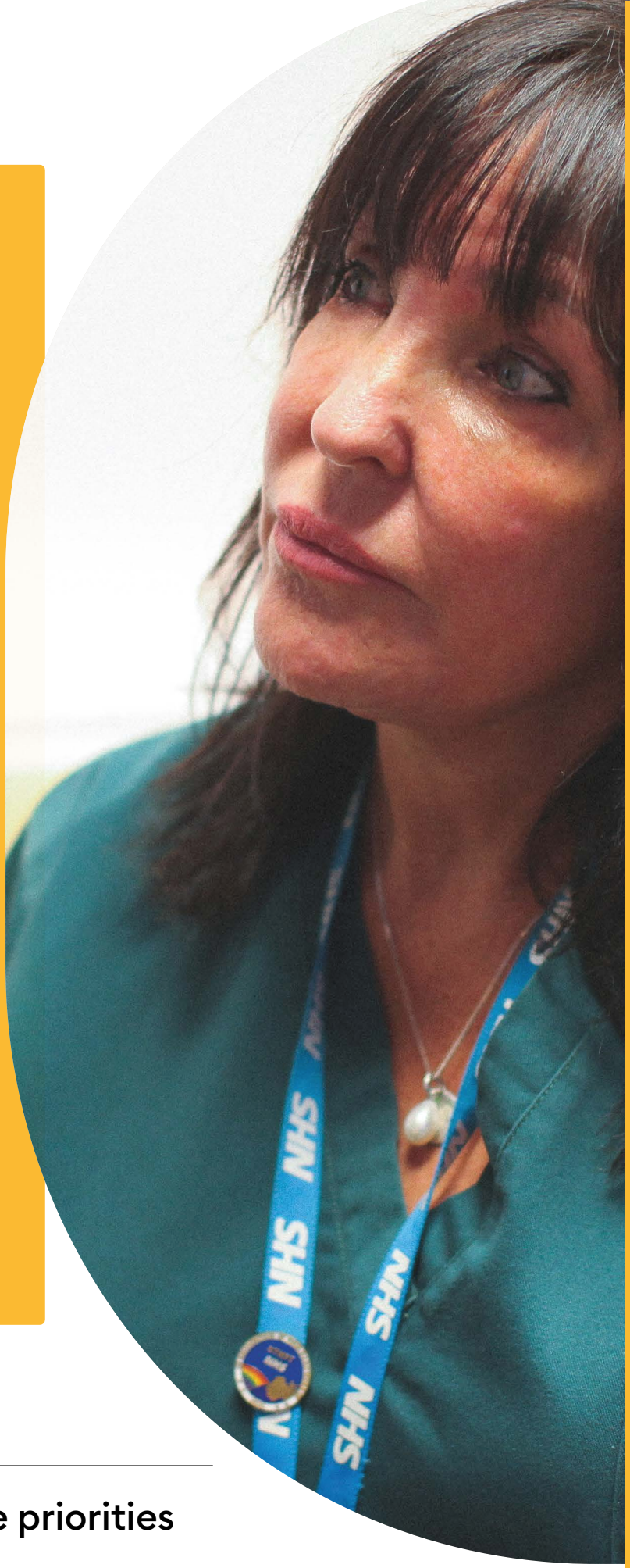
The case for action has never been stronger.

Health inequalities remain unacceptable. People experiencing homelessness continue to experience some of the poorest health outcomes in society.

What's more, pressure on hospitals continues to grow. The increase in homelessness is driving higher demand for emergency care; longer hospital stays and repeated admissions. This is at a time when the NHS is already under unprecedented pressure.

There is now a clear alignment with national policy on health, care and homelessness; the new Prime Minister, Andy Burnham, has committed to ending rough sleeping, while the NHS is prioritising prevention, neighbourhood health and reducing health inequalities.

Crucially, the NHS is shifting towards Neighbourhood Health. The future NHS model depends on prevention, partnership working and supporting people in communities rather than repeatedly treating preventable crises in hospital.



Pathway helps deliver these priorities

By connecting hospital care with housing, primary care and community services, Pathway enables NHS organisations to improve outcomes for patients while delivering measurable operational and financial benefits.

Trevor's* story:

From mental health crisis to a permanent home

*Name changed

Trevor, a man in his forties, was admitted to the City & Hackney Centre for Mental Health following a severe psychotic episode that had led to the breakdown of family relationships.

Alongside acute mental illness and suicidal thoughts, he now faced another crisis; he no longer had anywhere safe to live.

Without specialist intervention, Trevor was at significant risk of leaving hospital into homelessness or unsuitable temporary accommodation.

The Hackney Pathway Team looked beyond his immediate mental health needs. Following a comprehensive multidisciplinary assessment, the team recognised that while he did not require highly specialised supported housing, he would need sustained practical support to rebuild his independence.

They secured a place at Lowri House, a specialist step-down facility, where Trevor began to recover in a stable environment while building trusting relationships with staff.

A dedicated community link worker provided consistent one-to-one support, accompanying him to appointments, helping him navigate benefits and acting as a single point of contact throughout his recovery.

When temporary accommodation became available, the team coordinated a smooth transition and continued supporting him until a permanent tenancy in Hackney was secured.

Today Trevor is living independently in permanent accommodation.

Why this matters

Without coordinated support across hospital, housing and community services, this patient would have faced a high risk of homelessness, relapse and repeated admission. Instead, he was able to rebuild his life with the stability needed to support his ongoing recovery.

1. Executive Summary: This year's impact at a glance

"Better care. Better outcomes. Better value."

Hospital teams supported on the Pathway Partnership Programme improve patient outcomes, reduce pressure on hospitals and deliver a measurable return on NHS investment.

Across England and Wales, teams supported on the Programme are helping NHS organisations respond to one of the most complex and costly challenges facing the health service. Working alongside hospitals, commissioners and community partners, specialist multidisciplinary teams improve care for people experiencing homelessness while reducing avoidable demand on NHS services.

In 2025/26 the programme demonstrated that better care for patients also delivers better value for the NHS and supports national policy directives.

2025/26 impact for patients

Almost 2000 people experiencing homelessness and severe exclusion received specialist support through teams on the Pathway Partnership Programme.

These outcomes have a real impact. They reduce repeat crises, improve recovery and help people remain engaged with healthcare after they have been discharged.

57% **reduction in return to rough sleeping**

64% **reduction in return to insecure accommodation**

79% **supported to register with a GP**

2025/26 impact for the NHS

The teams on the programme also delivered significant operational and financial benefits, with £5.39 returned for every £1 invested.

These savings are achieved because of shorter hospital stays, safer discharge pathways and fewer avoidable readmissions.

£6.4 million
net NHS savings

9,000
hospital bed days released

£1.3 million
average annual saving per hospital team

Supporting NHS priorities

The Partnership Programme directly supports national priorities by helping NHS organisations to:

- reduce health inequalities
- end discharge to rough sleeping and help end homelessness
- improve urgent and emergency care performance
- deliver neighbourhood health
- strengthen prevention and integrated working.

The Pathway Partnership Programme works within NHS systems, bringing healthcare together with housing and community partners around people with the most complex needs.

This report demonstrates:

- the impact Pathway delivers for patients
- the value created for NHS commissioners
- the results achieved across local services
- how the model can be commissioned
- the evidence underpinning its return on investment.

A national opportunity

The results achieved by existing Pathway teams demonstrate significant potential for wider adoption. Pathway has identified an additional 40 NHS Trusts where the model could deliver substantial benefit.

The potential annual impact includes:

£52 million NHS savings

£27 million wider public service savings

thousands fewer discharges to rough sleeping

reduced pressure on hospitals and emergency care.

2. A Better Way: What evidence tells us about effective hospital responses

"The Pathway Partnership Programme provides a proven, evidence-based model that helps NHS organisations improve outcomes for people experiencing homelessness while reducing pressure on hospitals and delivering better value."

The challenge for the NHS

Homelessness is one of the NHS's greatest health inequality challenges.

People experiencing homelessness experience some of the poorest health outcomes in England. The average age of death of people sleeping rough is just 43 for women and 45 for men, with many dying from preventable and treatable conditions[ii].

For NHS organisations, the challenge extends beyond poor health. Years of exclusion from mainstream services mean many patients present to hospital with multiple, overlapping needs that cannot be addressed through clinical treatment alone.

For example:

Clinical frailty
Affecting almost half of adults aged 18–59 and a quarter of those aged 18–25[iii].

Tri-morbidity
A third experience a combination of physical illness, mental ill health and substance dependence[iv].

Complex trauma
Almost nine in ten report difficult childhood experiences that continue to affect their health and engagement with services[v].

Multiple long-term conditions
Including asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease, tuberculosis and hepatitis C, at rates far exceeding the wider population[vi].

For hospitals, the challenge is not simply treating illness. It is coordinating healthcare, housing, safeguarding, welfare and community support to enable safe recovery and prevent repeated crises.

Why homelessness matters to NHS organisations

Barriers to timely primary, community and preventative care mean homelessness places disproportionate demand on hospitals.

Compared with people who are housed, people experiencing homelessness are:

Six times more likely to attend A&E.

Four times more likely to be admitted to hospital.

Likely to spend three times longer in hospital once admitted.

A growing system challenge

Detailed modelling suggests that at least 176,000 people experiencing homelessness are admitted to hospital in England every year, 50% more than the number of stroke related admissions[viii]. Yet many hospitals lack the specialist teams and support needed to respond effectively.

Without coordinated support, patients are more likely to experience prolonged hospital stays, delayed or fragmented discharge planning and discharge to unsuitable accommodation or the street.

The result is that hospitals often treat the same individuals repeatedly without addressing the underlying causes that bring homeless patients back to hospital again and again.

Unsafe discharge creates avoidable demand

Discharge remains one of the greatest challenges. Implementation of NICE guidance[ix] and adherence to the Duty to Refer[x] remains patchy, and so people experiencing homelessness are still often discharged unsafely: without proper coordination with other services, adequate planning or to suitable accommodation.

As a result:

- **In 2024/25, there were more than 10,000 occasions where someone was discharged from hospital to the street – a 17% increase on the previous year[xi].**
- **A previous study showed that 27% are readmitted within six months[xii].**

Unsafe discharge is damaging for patients and costly for the NHS, contributing to avoidable readmissions, increased bed occupancy and continuing pressure on urgent and emergency care.

The financial impact on the NHS

Homelessness also carries a substantial financial cost.

The healthcare costs associated with a single person experiencing homelessness can be comparable with those of an 85-year-old in stable housing. Someone experiencing homelessness is estimated to use £4,298 of NHS services in just three months[xiii].

Repeated admissions, prolonged stays, delayed discharge and avoidable emergency attendances therefore represent a significant recurring financial burden.

Previous research suggested homelessness costs a typical hospital Trust around £5 million each year[xiv]; more recent research indicates the true cost could be five to eight times higher[xv]. The challenge for commissioners is therefore both to improve care and reduce avoidable demand across the health and care system.

The Pathway Partnership Programme

The Pathway Partnership Programme provides NHS organisations with a proven, evidence-based response[xvi]. The programme helps the NHS adopt a best practice intervention, improving care quality, patient outcomes and safety.

Combining over 60 years' clinical expertise, lived experience and nationally recognised research, Pathway helps commissioners and providers translate policy into practical service improvement.

Helping NHS organisations:

- Improve outcomes for people experiencing homelessness and severe exclusion.
- Reduce avoidable demand through safer discharge and better continuity of care.
- Strengthen workforce capability through specialist expertise, training and support.
- Integrate health, housing and community services.
- Deliver financial savings while supporting national policy priorities.
- Meet statutory duties and NICE Guideline 214.

From insight to implementation: what the Programme delivers

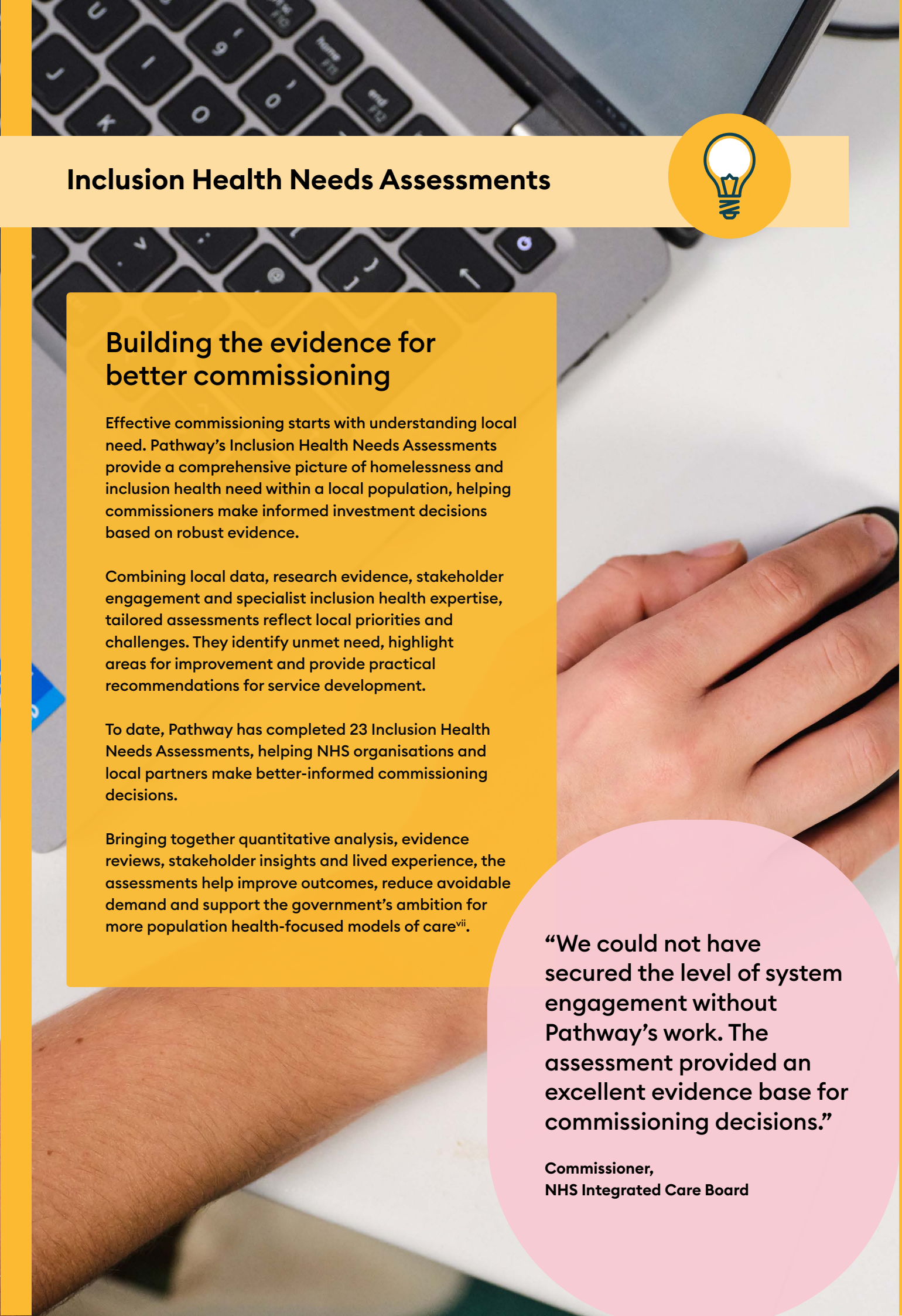
Pathway's support is designed around local need. Flexible support packages are developed in partnership with each Trust, allowing organisations to access the combination of Pathway's services that best meets their priorities and drives sustainable improvement:

Understanding local need through Inclusion Health Needs Assessments
Identifying unmet need, quantifying demand and informing commissioning decisions.

Delivering specialist services through Pathway Hospital Teams
Implementing, training and supporting clinically led multidisciplinary NHS hospital teams.

Improving systems with consultancy support
Helping NHS organisations redesign services, strengthen pathways and implement sustainable change.

Inclusion Health Needs Assessments



Building the evidence for better commissioning

Effective commissioning starts with understanding local need. Pathway's Inclusion Health Needs Assessments provide a comprehensive picture of homelessness and inclusion health need within a local population, helping commissioners make informed investment decisions based on robust evidence.

Combining local data, research evidence, stakeholder engagement and specialist inclusion health expertise, tailored assessments reflect local priorities and challenges. They identify unmet need, highlight areas for improvement and provide practical recommendations for service development.

To date, Pathway has completed 23 Inclusion Health Needs Assessments, helping NHS organisations and local partners make better-informed commissioning decisions.

Bringing together quantitative analysis, evidence reviews, stakeholder insights and lived experience, the assessments help improve outcomes, reduce avoidable demand and support the government's ambition for more population health-focused models of care[vii].

"We could not have secured the level of system engagement without Pathway's work. The assessment provided an excellent evidence base for commissioning decisions."

Commissioner,
NHS Integrated Care Board

Pathway Hospital Teams

Specialist multidisciplinary teams that improve outcomes and reduce demand

At the heart of the Partnership Programme is Pathway's specialist hospital team model.

With experience of working alongside 22 NHS Trusts, Pathway helps launch, trains and supports clinically led multidisciplinary teams that improve care for patients experiencing homelessness while helping hospitals manage one of their most complex patient groups more effectively.

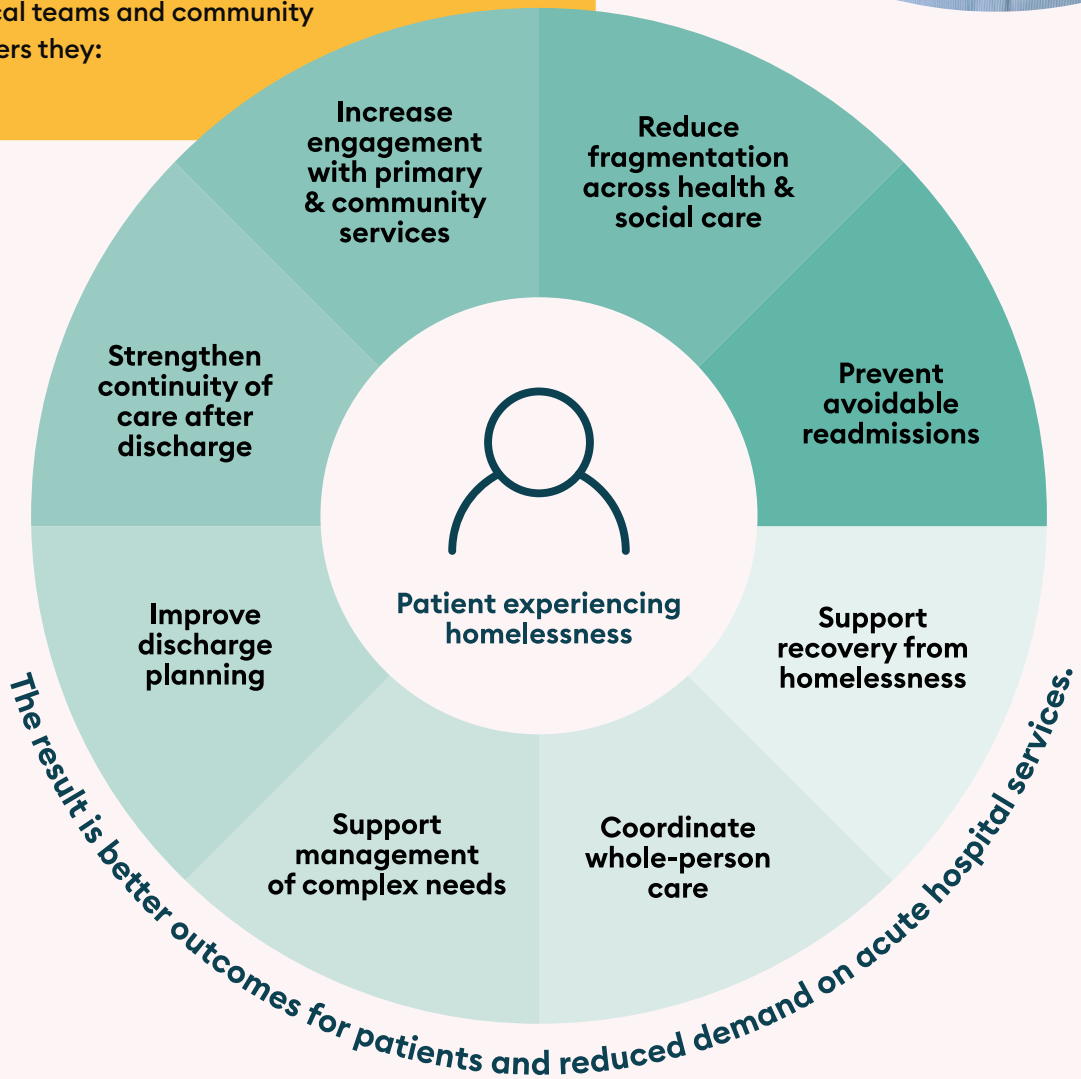
The specialist training prepares teams to meet the unique challenges they will face delivering this multidisciplinary, boundary crossing service model to support patients with highly complex needs.

Bringing together health, housing and community support

Pathway teams are intensely multidisciplinary and work across the boundaries between health, housing, social care and many other services than can help homeless patients.

Depending on local need, teams may include GPs, nurses, housing specialists, social workers, occupational therapists, physiotherapists and care navigators. This multidisciplinary approach enables hospitals to address the wider factors affecting recovery rather than focusing solely on immediate clinical care.

Pathway teams identify and connect with these vulnerable patients, supporting them to engage with their care in hospital. Working closely with medical teams and community partners they:



It is a model built on evidence

Pathway's multidisciplinary approach reflects more than fifteen years of research (including a randomised controlled trial[xviii]), service development and frontline experience.

NICE recognises this as an effective model for supporting people experiencing homelessness through clinically-led psychologically informed and relationship-based care.

Evidence demonstrates that this approach can achieve:

30% — **reduction in hospital bed days**[xix]

50% — **reduction in overall service costs**[xx]

£1.8M — **savings in wider rough sleeping costs**[xxi]

£1M — **savings for individual NHS Trust**[xxii]

Inclusion Health Consultancy

Turning evidence into system change

Better outcomes require not only specialist clinical services, but health systems designed around the needs of people experiencing the greatest exclusion.

Pathway's Inclusion Health Consultancy helps NHS organisations turn national policy into practical, locally deliverable solutions.

Working with NHS Trusts, Integrated Care Boards, local authorities and other partners, Pathway combines expertise in healthcare, housing, research and service development to redesign services, strengthen pathways and improve outcomes.

Every project is tailored to local priorities, operational pressures and commissioning objectives.

Whether developing a new inclusion health service or strengthening existing provision, Pathway can offer the knowledge, expertise and practical implementation support needed to deliver sustainable change.

How the Programme helps deliver national priorities

Helping commissioners meet policy, statutory duties, and NHS priorities

The Pathway Partnership Programme provides NHS organisations with a practical way to meet legal duties, deliver national policy, reduce health inequalities and improve system performance.

Supporting the shift to neighbourhood health

National policy increasingly focuses on prevention, partnership working and supporting people closer to home. Pathway supports this shift by helping patients leave hospital safely connected to primary care, housing and community services, reducing avoidable readmissions and supporting longer-term recovery.

Reducing health inequalities

People experiencing homelessness face some of the most extreme health inequalities. The Partnership Programme provides commissioners with an evidence-based approach to reducing these inequalities while supporting the NHS Medium Term Planning Framework, Strategic Commissioning Framework and Core20PLUS5.

Ending discharge to rough sleeping

The Labour Government has recently committed to ending discharge from hospital to rough sleeping. Pathway hospital teams provide the specialist coordination, housing expertise and partnership working needed to turn this ambition into operational reality.

Improving urgent and emergency care

By reducing avoidable admissions, improving discharge planning and strengthening continuity of care, Pathway helps reduce unnecessary demand on acute services, improving patient flow, bed capacity and urgent and emergency care performance.

Strengthening population health management

People experiencing homelessness remain largely invisible within routine NHS datasets. Through specialist services, data collection and needs assessments, Pathway helps commissioners understand local need, target resources effectively and evaluate impact.

"All our patients are in crisis when they are referred to our team but, with the right interventions during their admission, they have been able to be discharged into safe, secure housing, engage to improve their health, beat addiction, return to work and reunite with family."

GP and Clinical Lead, St George's Homelessness Inclusion Team

3. Improving outcomes for patients and the NHS in 2025/26

Partnership Programme activity in the last 12 months

"The Pathway Partnership Programme delivers measurable improvements for patients while reducing pressure on NHS services and creating lasting value for commissioners."

Better outcomes for patients. Better outcomes for the NHS.

In 2025/26, Pathway supported six specialist hospital teams who worked with over 1,800 homeless patients.

Behind every number is a patient with complex and often multiple needs. Working alongside NHS colleagues and partner organisations, Pathway teams helped people access safer care, more appropriate housing and better support after discharge, while reducing avoidable pressure on hospitals.

Despite growing complexity, operational pressures and financial uncertainty, teams consistently demonstrated how specialist multidisciplinary support can improve outcomes for individuals and the wider health and care system.

Patients are presenting with increasingly complex needs

The teams Pathway supported in the last 12 months work with patients experiencing complex combinations of homelessness, severe and acute conditions, long-term physical illness, serious mental illness, substance dependence, cognitive impairment, disability, safeguarding concerns and frailty.

During 2025/26, every Partnership Programme team reported a marked increase in patient complexity.

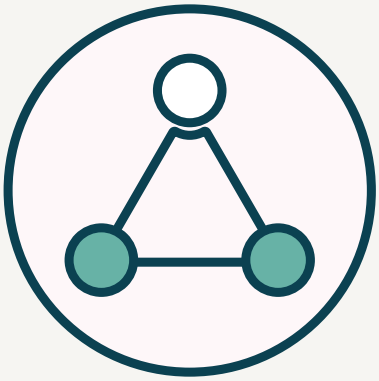
Increases in patient needs 2024/25 to 2025/26

56% → 75%

mental health needs

66% → 86%

substance use needs



44% → 70%

mental health and substance use needs

29% → 40%

mobility or access needs

Improving outcomes for people with the most complex needs

People experiencing homelessness rarely present with a single issue. Many need coordinated support across healthcare, housing, social care and the voluntary sector.

Throughout 2025/26, Pathway teams combined specialist clinical expertise with housing advocacy, practical assistance and sustained engagement to help patients access the care, accommodation and support they needed to recover safely.

Delivering consistently high-quality services

Continuous quality improvement is central to the Pathway Partnership Programme. The programme includes an evidence-based quality framework and set of indicators.

Throughout the year, teams strengthened service quality through audit, reflective practice, workforce development, specialist training and continuous improvement. Pathway teams show that specialist inclusion health services can deliver better individual care while supporting safer discharge, reducing avoidable demand and creating greater value for the wider NHS.

Performance improved across key quality indicators.

Pathway quality indicators

79% Patients supported to register with a GP

94% Patients receiving a holistic assessment

96% Patients discharged with a comprehensive care plan

75% Patients receiving housing advocacy

83% Patients assessed within two days of referral

Safer discharge. Better housing outcomes. Reduced pressure on hospitals.

One of the clearest measures of the programme's impact is helping patients leave hospital safely with the support they need to recover.

In 2025/26, Pathway teams achieved significant improvements in housing outcomes, reducing the likelihood of patients returning to crisis, rough sleeping or repeated hospital attendance.

Housing outcomes

57%

reduction in return to rough sleeping

64%

reduction in return to insecure accommodation ("sofa surfing")

Housing and health are closely connected. Discharge to rough sleeping or unsafe accommodation significantly increases the risk of deteriorating health, avoidable readmission and premature mortality.

By working with housing providers, local authorities and community services, Pathway teams secured safer discharge arrangements for patients whose needs extended well beyond healthcare.

Teams also prevented patients returning to other unsafe situations, including domestic abuse, violence and accommodation unable to support their health, mobility or care needs.

Reducing delayed discharge

Safe discharge is one of the greatest challenges facing hospitals caring for people experiencing homelessness. In 2025/26, only 11% of Pathway patients experienced a delayed discharge, around a quarter of the national rate.

This is particularly significant given the complexity of patients' health, housing, safeguarding and social care needs.

Through specialist multidisciplinary coordination, Pathway teams help patients leave hospital as soon as they are ready, with appropriate accommodation, healthcare and community support in place.

This reduces:

- delayed discharge
- failed discharge arrangements
- avoidable readmissions.

In 2025/26, only 11% of Pathway patients experienced a delayed discharge, around a quarter of the national rate.

Safer discharge planning

Better staff understanding of homelessness

Reduced stigma and increased compassion

Strengthening local systems

As demonstrated in the 2025/26 case studies in section five, the programme's impact extends beyond individual patients. Pathway teams operate within increasingly challenging local systems, facing:

- shortages of supported accommodation
- limited step-down provision
- stretched local authority housing services
- fragmented care pathways
- gaps in services for people with co-occurring mental ill health and substance use
- increasing pressure on homelessness services
- stretched local authority care services

These pressures can leave patients stuck between organisational boundaries, contributing to delayed discharge, repeated admissions and poorer outcomes.

Despite this, teams have developed new referral pathways, integrated discharge processes, made greater use of step-down services, outcome dashboards and multidisciplinary case management arrangements, while building inclusion health expertise within hospitals.

Several teams have also influenced hospital-wide policies, improved staff understanding of homelessness, challenged stigma and strengthened discharge planning.

Building partnerships that improve outcomes

Strong partnership working underpins every successful Pathway team. Throughout 2025/26, teams strengthened collaboration between NHS organisations, local authorities, housing providers, social care, safeguarding, substance use services, community healthcare and the voluntary sector.

In Hull, the team invested in the strengthening of relationships across housing, safeguarding, substance use services and the Changing Futures Partnership, improving communication and accelerated discharge planning. At St George's, sustained collaboration led to Wandsworth Council embedding a dedicated housing officer within the hospital team, accelerating housing decisions and multi-agency working. In Plymouth, close collaboration between the NHS, Plymouth City Council and community partners has enabled safe discharge and ongoing support despite the absence of dedicated step-down accommodation.

These partnerships enable faster decision-making, safer discharge and more joined up care. Many teams now benefit from embedded housing specialists, shared referral pathways and regular multidisciplinary meetings, ensuring health, housing and social care decisions happen together rather than sequentially.

Pathway teams improve far more than individual patient care. By strengthening local systems, reducing delayed transfers of care and building more integrated local pathways, they deliver sustainable benefits for patients, hospitals and the wider NHS.

Better coordinated care

Improved patient outcome and experience

Efficient use of resources & reduced re-admission

Financial impact and value for money

Delivering value for the NHS

Improving care for people experiencing homelessness is not only the right thing to do; it is also a sound investment for the NHS.

In 2025/26, Pathway hospital teams demonstrated substantial financial and operational benefits through reduced hospital use, improved discharge and prevention of repeat crises.

> "The Pathway Partnership Programme delivers a measurable return on investment by reducing avoidable hospital use, releasing bed capacity and creating wider public sector savings."
>
> **Alex Bax,**
> **Pathway CEO**

Impact at a glance 2025/26

9,000
Hospital bed days released

£6.4m
Net NHS savings

£1.3m
Average saving per team

1,800
Average bed days released per team

£3.4m
Wider public savings

Reducing the pressure on hospitals

During 2025/26, the five reporting Pathway teams supported 1,817 patients, including 1,117 hospital inpatients.

People experiencing homelessness typically remain in hospital around three times longer than the average emergency admission[xxiii] because of their complex health, housing and social care needs – amounting to more than 30,000 hospital bed days.

Evidence shows that introducing a specialist Pathway team reduces bed occupancy for this patient group by around one third[xxiv].

Applied to the 2025/26 programme, this equates to:

- **9,000 hospital bed days released**
- **£8.2 million reduction in hospital utilisation costs.**

After team operating costs and Pathway's specialist support, the programme generated £6.4 million in net NHS savings.

For the average hospital, this represents:

- **1,800 bed days released**
- **£1.3 million net annual saving.**

Crucially, these benefits are achieved while improving patient outcomes, not by limiting care.

The opportunity for wider NHS adoption

There is significant potential to replicate these benefits nationally. Pathway has identified 40 additional NHS Trusts where the model could deliver similar improvements.

Based on current estimates, extending the programme could deliver:

- **more than 120,000 hospital bed days released**
- **over £50 million in annual NHS savings, after team and Pathway support costs.**

For commissioners, this represents an opportunity to improve care while increasing hospital capacity and reducing avoidable expenditure.

Creating value beyond the NHS

The benefits extend beyond hospitals. Preventing a return to rough sleeping also reduces demand across homelessness services, criminal justice, emergency services and local government.

In 2025/26, each Pathway team on average prevented one person a week from returning to rough sleeping, generating an estimated:

£3.4M

wider system savings

£1.89

returned for every £1 invested (non-health savings alone)

If replicated across a further 40 hospitals, the programme could prevent approximately 1,832 people from returning to rough sleeping each year, generating an estimated £27 million in wider public service savings.

> “When it comes to our patients, the biggest thing for us is digital exclusion. Getting mobile phones through Pathway has been a lifesaver because our clients simply can’t access services without them.”
>
> **Pathway Hospital Team member**

Added value for Partnership Programme teams

For teams in the support programme, Pathway continues to bring in extra charitable funding to give homeless patients practical help that the NHS does not provide.

During 2025/26, this included basic accommodation starter packs (in partnership with social enterprise Unpacked, including bedding, towels, and basic cooking equipment), mobile phones for patients, clothing, emergency food and travel, reflective practice for London teams and laptops for hospital teams

In London, Pathway’s continued advocacy persuaded NHS Integrated Care Boards to continue to fund access to specialist immigration legal advice for hospital teams.

Why this matters for commissioners

Every hospital is under pressure to improve patient flow, reduce delayed discharge and make better use of limited resources.

The Partnership Programme demonstrates that specialist inclusion health teams can do all three while improving care for some of the NHS’s most complex patients.

By combining better patient outcomes with measurable operational and financial benefits, Pathway offers commissioners an investment that strengthens individual care and wider NHS performance.

> “In my 30+ years of working, the most inspiring and proud thing I have been involved in is the set-up of this team. We wouldn’t have done it without your help. Every day, together, we’re saving lives and that’s what it comes down to.”
>
> **NHS regional commissioner of a Pathway Team.**

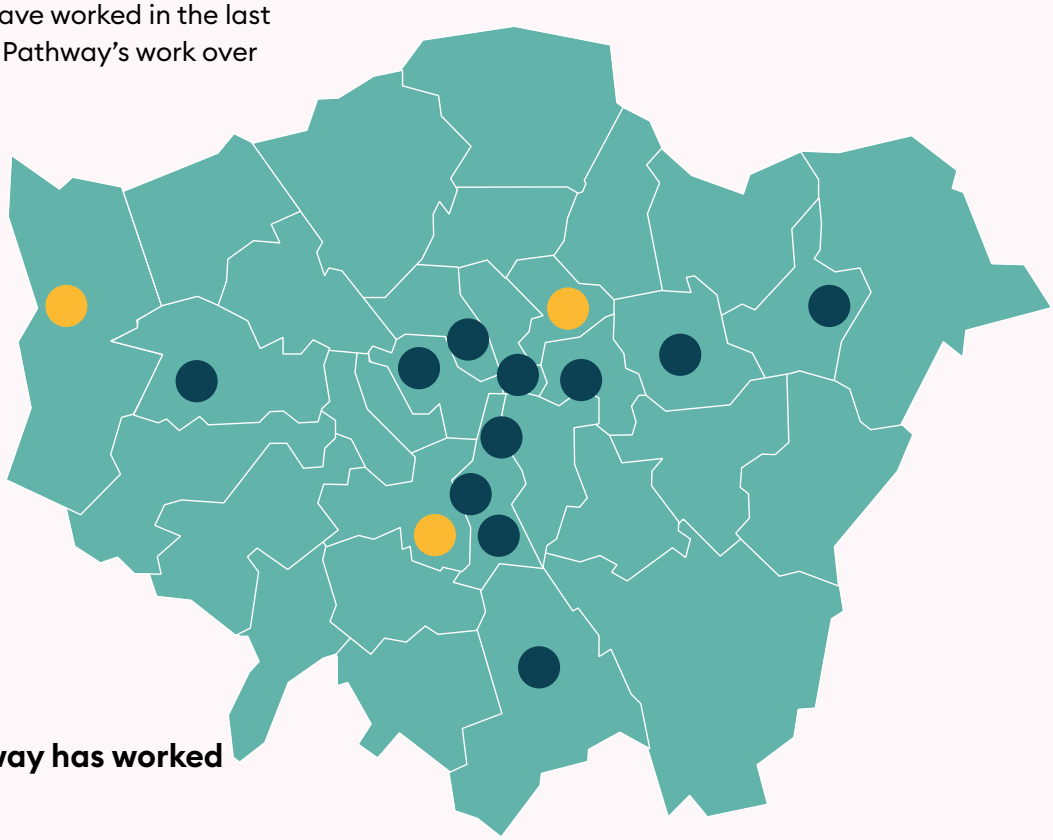
4. Pathway Partnership Programme in Practice 2025/26

Improving outcomes, strengthening systems and supporting commissioners in the last 12 months.

The best way to see what Pathway and the teams we support can achieve is to look at examples from around the country in the last 12 months. Set out in the pages that follow are reports that present the impact of the Pathway Hospital Teams, and our Inclusion Health Needs Assessments and consultancy.

The patient stories provided in this section have been anonymised. Names have been changed and identifiable details have been removed.

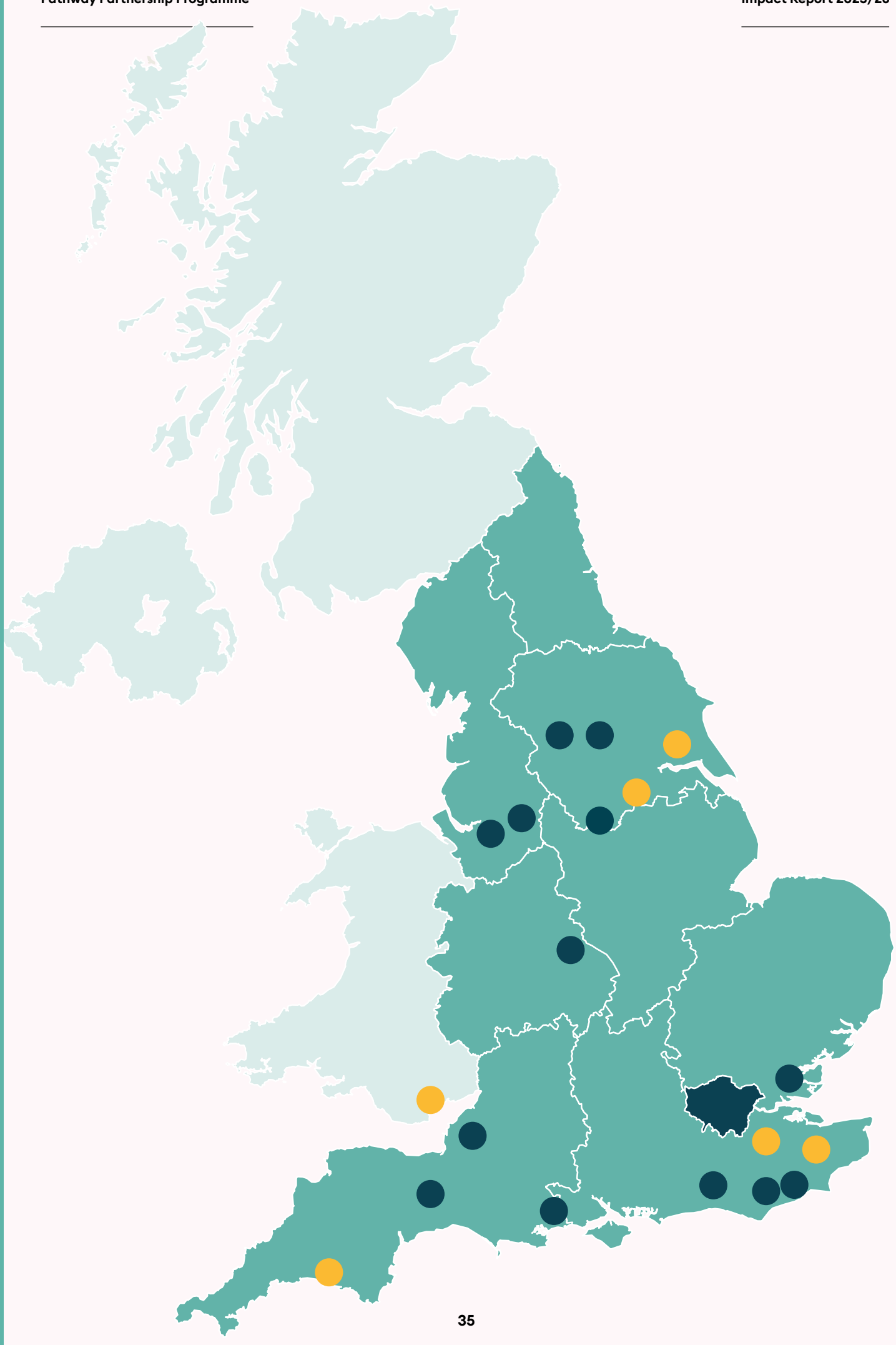
The map shows where we have worked in the last 12 months and the reach of Pathway's work over previous years.



NHS Trusts Pathway has worked alongside

NHS Trusts Pathway worked with in 2025/26

London



Cardiff and Vale Health Inclusion Service

Bringing hospital, housing and community services together

A multidisciplinary hospital team that acts as the bridge between healthcare, housing and community services, helping patients leave hospital safely while reducing pressure on the NHS.

Established	2025 (Hospital In-Reach Team)
Coverage	Cardiff and Vale University Health Board, supporting patients across Cardiff, the Vale of Glamorgan, Rhondda Cynon Taf, Caerphilly and Newport
Commissioned by	Cardiff and Vale University Health Board
Delivery partners	CAVHIS, Cardiff City Council and a wide network of statutory and voluntary sector partners

The challenge

CAVHIS In-reach Team patients have complex combinations of need. Self-neglect, fluctuating mental capacity, poorly managed chronic disease, and safeguarding concerns are often seen. Patients frequently face barriers to primary care, fragmented support and repeated hospital admissions because no single organisation can meet all their needs. There are further challenges in Cardiff because patients often come from several neighbouring local authority areas, each with different housing pathways and support arrangements.

> **“The staff are really friendly—they make every effort to help me.”**
>
> **Patient**

The Response

The Cardiff Health Inclusion Service (CAVHIS) In-reach Team works across the Emergency Unit and inpatient wards at the University Hospital of Wales, providing specialist support for people experiencing homelessness and other inclusion health groups. Rather than operating as a separate service, the team acts as the "glue" connecting hospital services, primary care, housing, social care and the voluntary sector. Working as part of the wider CAVHIS service, the team supports patients from admission through to safe discharge and ongoing recovery, ensuring they receive coordinated healthcare, housing and community support.

The service works with five inclusion health groups who experience some of the poorest health outcomes:

- people experiencing multiple exclusion homelessness
- refugees and people seeking sanctuary, including those with no recourse to public funds
- sex workers
- vulnerable people involved with the criminal justice system
- Gypsy, Roma and Traveller communities who are not engaged with healthcare.

"No judgement—they took my pain away."

Patient

"Working in partnership, CAVHIS has led to a truly joined-up approach, delivering better outcomes across health, housing and wider support services...

... Through proactive collaboration, service users have benefited from improved coordination and greater long-term stability."

Cardiff Council Housing Manager

2025/26 Highlights

Demonstrating value for commissioners

The team developed an innovative outcomes dashboard that compares hospital activity before and after patients receive CAVHIS support. By tracking admissions, emergency attendances and bed days, the dashboard provides commissioners with clear evidence of the financial and operational value created through specialist inclusion health services.

Simplifying access across five local authorities

Working with local partners to implement the Welsh Government's Ask and Act legislation, the team introduced a single referral process covering Cardiff, the Vale of Glamorgan, Rhondda Cynon Taf, Caerphilly and Newport. The new pathway provides agreed referral routes, response times and escalation processes, making it easier for hospital staff to access housing support while improving communication between NHS organisations and local authorities.

Bringing services together

A new multi-agency hub, developed in partnership with Cardiff Council, now brings together housing, adult social care, CAVHIS clinics and a multidisciplinary team including occupational therapists, physiotherapists and nutrition specialists. This enables patients to access multiple services in one place, reducing duplication and speeding up decision-making.

Preventing patients falling through the gaps

The team coordinates care across multiple hospital specialties, including respiratory medicine, hepatology, infectious diseases and mental health, ensuring patients with highly complex needs receive coordinated follow-up rather than becoming lost between services.

Preventing crises before they happen

Recognising high levels of respiratory disease among people experiencing homelessness, CAVHIS introduced winter outreach clinics in local hostels, providing spirometry, vaccinations and prescribing closer to where people live.

The team also launched a nurse-led drop-in service for young people living in hostels, helping prevent avoidable attendance at emergency departments.

Daniel's story:

A safe recovery despite having no recourse to public funds

When Daniel was admitted to hospital following a serious road traffic collision, his injuries were only one part of the challenge.

He had no recourse to public funds and had been sleeping on sofas of acquaintances, a situation which is often risky and precarious. Although the hospital identified his homelessness and referred him to the CAVHIS In-reach Team, his immigration status meant he was not eligible for statutory housing support.

Without specialist intervention, he was at real risk of leaving hospital with nowhere safe to recover.

The team immediately coordinated support. They completed a comprehensive health assessment, registered him with healthcare services and submitted an Ask and Act (Duty to Refer) referral to the local authority. When this failed to secure housing because of his immigration status, they worked with the British Red Cross to explore his legal options while urgently identifying alternative accommodation through the voluntary sector.

A local hostel agreed to provide Daniel with temporary accommodation, allowing him to recover safely after discharge.

Working together, health services, voluntary organisations and specialist inclusion health professionals continued to support him until he was able to move into his own privately rented accommodation.

Today Daniel is registered with a mainstream GP, living independently and no longer requires homelessness services.

Without the coordinated intervention of the CAVHIS team, this patient would almost certainly have been discharged into homelessness, placing both his recovery and future health at significant risk.

Why this matters

The Cardiff team demonstrates how specialist inclusion health services improve outcomes by bringing together organisations that rarely work as one system. By acting as the link between hospital care, housing, primary care and community services, the team is helping patients recover more safely while reducing unnecessary pressure on hospital services.

39

East Kent Homeless Health Team

Delivering coordinated inclusion health support across three hospitals serving East Kent's diverse rural, coastal and urban communities

A multidisciplinary team helping people experiencing homelessness recover safely after hospital while reducing avoidable admissions, improving discharge and strengthening partnership working across a large and geographically complex health system.

Established	2021
Coverage	Queen Elizabeth the Queen Mother Hospital, William Harvey Hospital and Kent & Canterbury Hospital
Commissioned by	NHS Kent and Medway Integrated Care Board
Delivery partners	East Kent Hospitals University NHS Foundation Trust, Canterbury City Council, Porchlight and Forward Trust

The challenge

East Kent covers a large and diverse population with significant levels of deprivation, rural isolation and coastal homelessness.

Many patients supported by the team have multiple long-term health conditions alongside mental ill health, substance dependence, cognitive impairment and housing insecurity. Others face additional barriers such as digital exclusion, lack of identification, or no recourse to public funds.

Limited supported accommodation and increasing pressure on statutory services mean many people fall between organisational thresholds, considered too complex for housing services but not meeting the eligibility criteria for social care support.

Without specialist intervention, these patients often experience repeated hospital admissions, prolonged stays and unsafe discharge, creating avoidable pressure on NHS services.

Impact in numbers April 2025 to March 2026

489 Referrals received

247 Comprehensive interventions

130 Brief interventions

The Response

The East Kent Homeless Health Team combines hospital in-reach, community follow-up and specialist step-down accommodation to support patients from admission through to recovery.

Working across acute hospitals and in partnership with housing, social care and voluntary organisations, the team provides coordinated support that extends beyond discharge, helping people rebuild stability while reducing future reliance on emergency care.

Clinical expertise sits alongside housing knowledge, ensuring decisions about healthcare, accommodation and ongoing support are made together rather than in isolation.

> “You’ve saved my life. I don’t trust many people, but the support and compassion I’ve received from the Homeless Health Team means I can honestly say I trust you.”
>
> **Patient**

> “Thank you for supporting a patient the whole ward was worried about. Seeing him leave hospital with somewhere safe to recover was fantastic. We genuinely don’t know what we would do without this team.”
>
> **Ward Sister**

2025/26 Highlights

Reducing repeat hospital attendance

By helping patients leave hospital with safe accommodation and coordinated community support, the team has reduced discharge to the street and interrupted the cycle of repeated emergency attendances and avoidable admissions.

Supporting recovery beyond hospital

Intensive case management continues after discharge, helping patients remain engaged with healthcare, sustain their accommodation and access wider support.

This longer-term approach reduces the likelihood of crisis-driven readmission while supporting lasting recovery.

Improving patient flow

The team's five-bed step-down service, delivered in partnership with Porchlight, provides a vital bridge between hospital and permanent accommodation. Patients who are medically fit for discharge but have nowhere safe to recover can leave acute hospital earlier, releasing beds while ensuring recovery continues in an appropriate setting.

Faster, safer decision-making

There are strong relationships with local authorities, housing providers, substance use services and voluntary organisations. This enables rapid multidisciplinary decision-making and reduces delays caused by fragmented systems.

Bringing housing expertise into hospital

An embedded Homeless Health Housing Officer ensures housing assessments begin while patients are still in hospital. By addressing housing needs early, the team reduces delayed discharge, prevents discharge to the street and lowers the risk of avoidable readmission.

Building future workforce capacity

The team is developing a GP training placement focused on inclusion health and health inequalities, helping build specialist expertise for the future while strengthening the local healthcare workforce.

Challenging decisions that leave patients at risk

Using clinical evidence and multidisciplinary advocacy, the team regularly challenges housing decisions that fail to recognise patients' vulnerability.

Rosie's story

How coordinated support transformed Rosie's future

When Rosie lost a close family member, her life began to unravel. Bereavement led to increased alcohol use, the loss of her job, relationship breakdown and eventually homelessness.

Within two months she had attended A&E 12 times and been admitted to hospital three times. She was living with severe self-neglect, deteriorating physical health and acute mental distress. During one admission she told staff she had "no reason to live."

Although the team immediately raised safeguarding concerns and submitted a Duty to Refer, Rosie was assessed by the local authority as not being in priority need for housing. Adult Social Care was also contacted but no support was forthcoming.

Without specialist intervention, she would almost certainly have returned to homelessness and continued cycling through emergency services. Instead, the East Kent Homeless Health Team coordinated an intensive package of support.

Working with Porchlight, they secured emergency accommodation through the Rapid Rehousing Fund. Forward Trust provided specialist alcohol support.

The team helped Rosie claim benefits, obtain essential household items and, crucially, used detailed clinical evidence to challenge the local authority's housing decision. Their advocacy was successful. The original decision was overturned and Rosie moved first into temporary accommodation before securing a permanent home.

One year later, Rosie is no longer homeless. Her health has improved significantly. She has returned to work, earned a promotion and is rebuilding her life.

Without coordinated clinical advocacy, Rosie would almost certainly have remained trapped in the cycle of homelessness, repeated hospital admission and deteriorating health.

Why this matters

The East Kent team demonstrates that specialist inclusion health services do far more than support individual patients. By combining healthcare, housing and community support into a single coordinated pathway, the team improves patient outcomes while helping hospitals reduce avoidable admissions, improve patient flow and make better use of scarce resources.

Hackney Pathway Homeless Team

Bridging acute hospitals, mental health services and community care to prevent unsafe discharge and reduce avoidable readmissions

One of only three Pathway teams nationally working across both acute and inpatient mental health services, Hackney demonstrates how integrated multidisciplinary care improves outcomes for some of the NHS's most vulnerable patients while reducing avoidable hospital use.

Established	January 2022
Coverage	Homerton Hospital, Regional Transitional Neurological Rehabilitation Units and the City & Hackney Centre for Mental Health
Commissioned by	North East London Integrated Care Board
Delivery partners	The Homerton University Hospital NHS Foundation Trust, North East London NHS Foundation Trust, Hackney Council, Providence Row and Peabody Housing Association

The challenge

Hackney supports one of the most clinically complex inclusion health populations in London. Many patients are admitted with advanced illness that has gone untreated for years, alongside severe mental ill health, cognitive impairment, substance dependence and housing insecurity.

Increasingly, the team is supporting people with:

- advanced long-term health conditions
- undiagnosed cognitive impairment
- complex neurological rehabilitation needs
- co-occurring mental ill health and substance dependence
- poorly controlled diabetes
- sickle cell disease complicated by homelessness and social vulnerability.

Alongside increasing clinical complexity, the team faces significant system pressures, including overstretched housing services, longer waits for accommodation and higher thresholds for statutory support.

Without specialist intervention, many of these patients would face prolonged hospital stays or discharge into homelessness or unsuitable accommodation.

The Response

The Hackney Pathway Team provides specialist hospital in-reach across both acute and mental health settings, supported by community follow-up and a dedicated six-bed step-down facility, Lowri House.

Working across organisational boundaries, the team brings together healthcare, housing and community support to ensure patients receive coordinated care from admission through to recovery.

This integrated model enables patients to leave hospital safely while reducing avoidable readmissions and supporting long-term independence.

> "Handled a complex case exceptionally well, with excellent communication throughout."
>
> **Specialist Sickle Cell Team**

> "Thank you so much... What a great kindness from your team.
>
> I pray God blesses everyone who made this possible."
>
> **Patient**

Impact in numbers April 2025 to March 2026

330 Referrals received

135 Comprehensive interventions

128 Brief interventions

2025/26 Highlights

Supporting recovery beyond hospital

The team's post-discharge support combines housing casework with practical resettlement and intensive one-to-one support. Delivered through community link workers and the six-bed Lowri House step-down service, this approach helps patients maintain their recovery while significantly reducing the likelihood of avoidable readmission.

Improving safe discharge

The team's occupational therapist provides specialist functional and cognitive assessments that generate the clinical evidence required to support Care Act assessments and secure appropriate social care funding. This enables safer discharge while reducing unnecessary delays and releasing acute hospital beds.

Improving mental health discharge

Hackney is one of only three Pathway teams working directly within inpatient mental health services. By bringing specialist housing and safeguarding expertise into mental health wards, the team prevents unsafe discharge and ensures housing needs are addressed alongside mental health recovery.

Influencing care beyond the team's caseload

The team's expertise extends well beyond individual patients. Working across A&E and inpatient wards, staff provide advice on housing options, safe discharge planning and inclusion health, helping clinicians make better-informed decisions that improve patient care and reduce downstream demand.

Building inclusion health expertise

An embedded Homeless Health Housing Officer ensures housing assessments begin while patients are still in hospital. By addressing housing needs early, the team reduces delayed discharge, prevents discharge to the street and lowers the risk of avoidable readmission.

Building future workforce capacity

Training delivered to therapists, safeguarding teams and wider hospital staff has improved understanding of homelessness, challenged stigma and strengthened discharge planning across both acute and mental health services.

Dorothy's story

Helping a woman with sickle cell disease rebuild her life after domestic abuse

Dorothy was admitted during a severe sickle cell crisis after fleeing domestic abuse.

Dorothy arrived at A&E in crisis, with a sickle cell episode further complicated by a sudden serious illness. During her admission she disclosed that she was experiencing domestic violence and financial abuse. Having become homeless overnight, she faced the loss of both her housing and income, and was also facing severe, life-changing mobility problems resulting from her condition.

Recognising that recovery depended as much on safe housing as clinical treatment, the Pathway team coordinated support across safeguarding services, specialist sickle cell clinicians and housing providers.

The occupational therapist completed a detailed functional assessment that demonstrated the impact of Dorothy's health condition and identified her equipment, care and environmental needs.

Alongside this, the team gathered comprehensive evidence for her homelessness application, providing the clinical evidence and multidisciplinary housing advocacy needed to ensure Dorothy's circumstances and needs were fully recognised. They supported her through benefits concerns, arranged community occupational therapy and provided essential household items through Pathway's Unpacked Box initiative, our accommodation starter packs.

As a result, she moved into safe accommodation while remaining under the care of the specialist sickle cell service she relied upon. Her recovery continued with stability, dignity and ongoing clinical support.

Without specialist multidisciplinary support, Dorothy would have faced a high risk of homelessness, poor health outcomes and further crisis. Instead, she left with safe accommodation, ongoing specialist care and the stability needed to support her recovery.

Why this matters

The Hackney team demonstrates the value of integrating acute care, mental health services, housing and community support around people with the most complex needs. By preventing unsafe discharge, strengthening post-discharge support and improving multidisciplinary decision-making, the team helps patients recover more safely while reducing avoidable demand on hospitals and mental health services.

Hull Homeless Health Inclusion Team

Delivering safe discharge and coordinated care for one of the NHS's most complex patient groups, even without step-down accommodation

Hull demonstrates how strong multidisciplinary partnerships and specialist inclusion health expertise can deliver safe discharge and improve outcomes, even in a system without dedicated step-down beds.

Established	2017 – the longest-established Pathway Partnership team
Coverage	Hull Royal Infirmary, with support for referrals from Castle Hill Hospital
Commissioned by	Humber and North Yorkshire Integrated Care Board
Delivery partners	Hull University Teaching Hospital NHS Trust, Modality, Renew, Hull City Council and the Changing Futures Partnership

The challenge

Hull has experienced a significant increase in homelessness alongside high levels of deprivation, complex ill health and limited community provision.

Many patients supported by the team have multiple long-term health conditions, substance dependence, severe mobility problems and complex social care needs.

The team regularly supports people with:

- complex wound care and vascular disease
- poorly controlled diabetes
- advanced respiratory disease
- severe orthopaedic and rehabilitation needs
- overdose, intoxication and head injuries
- limb-threatening infections and amputations.

Many are frequent hospital attenders who face significant barriers to accessing healthcare, housing and social care.

Unlike many other areas, Hull has no hospital step-down accommodation, making safe discharge particularly challenging.

Without specialist coordination, many patients would remain in hospital unnecessarily or be discharged back to the street, placing both their recovery and future health at risk.

The Response

The Hull Homeless Health Inclusion Team provides specialist hospital in-reach, discharge planning and system coordination across Hull Royal Infirmary.

Working alongside hospital staff, housing providers, safeguarding teams, substance use services and community organisations, the team acts as the bridge between acute care and longer-term recovery.

As well as supporting individual patients, the team plays a wider leadership role by convening multidisciplinary meetings, advising local partnership forums and improving understanding of homelessness across the hospital.

> "I feel like you actually listen to me. You know what it's like out there."
>
> **Patient**

> "Working alongside the team has created a genuinely collaborative service. Sharing expertise and working together helps keep our most vulnerable patients safe and well. It would be a real loss to the local system if this service was no longer available."
>
> **Hospital Drug and Alcohol Support Team (Renew)**

Impact in numbers April 2025 to March 2026

361 Referrals received

332 Comprehensive interventions

14 Brief interventions

2025/26 Highlights

Delivering safe discharge without step-down accommodation

Although Hull has no dedicated hospital step-down beds, the team consistently achieves safe discharge through strong partnership working, expert discharge planning and close collaboration with housing providers and community services. Their ability to coordinate complex support enables patients to leave hospital safely while reducing the risk of avoidable readmission.

Strengthening hospital and community partnerships

Following changes to community funding, the team invested heavily in strengthening relationships across housing, safeguarding, substance use services and the Changing Futures Partnership. These partnerships have transformed communication between organisations and significantly improved the speed and coordination of discharge planning. Housing services now typically respond to Duty to Refer requests within 24 hours, a marked improvement on previous years.

Embedding safer discharge pathways

Working with hospital colleagues and community partners, the team developed a dedicated discharge pathway for people experiencing homelessness. Available through the Trust intranet, the pathway gives emergency department and acute medical staff clear guidance on delivering safer, more coordinated discharge planning.

Unlocking access to social care

Recognising that delays in Care Act assessments often prevent timely discharge, the team has developed innovative approaches to accelerate assessments. By coordinating real-time discussions between patients and social workers during hospital admission, the team has helped unlock appropriate care packages while reducing unnecessary delays.

Using data to prevent future crises

The team uses hospital activity data to identify patients who are becoming frequent attenders before patterns become entrenched. Working with Hull's multi-agency partnerships, they ensure these patients receive coordinated preventative support, reducing duplication while improving long-term outcomes.

Challenging stigma across the hospital

Working alongside people with lived experience, the team helped produce an educational film that is now being used across the Trust to improve understanding of homelessness and reduce stigma. Training has also increased awareness of referral pathways and strengthened discharge planning across frontline services.

Gerry's story

How specialist advocacy transformed the future of one of Hull's most frequent hospital attenders

Over twelve months Gerry attended A&E multiple times and was admitted to hospital on over 30 occasions.

He was a wheelchair user, had severe pressure wounds, necrotic toes, osteomyelitis, pelvic bone deterioration and a permanent urinary catheter. His health was further complicated by cognitive impairment, making it difficult for him to engage with treatment or navigate services.

Repeatedly, he discharged himself before treatment was complete. On other occasions Gerry left hospital without wound dressings, pain relief or appropriate accommodation, returning to the street where his health rapidly deteriorated.

Each admission became another cycle of crisis. When Gerry was referred to the Homeless Health Inclusion Team, their priority was not another referral, it was building trust. Over time, the team developed a therapeutic relationship that enabled Gerry to remain in hospital long enough to complete treatment.

They coordinated safeguarding referrals, convened multi-agency risk management meetings and worked across health, housing and social care to develop a single coordinated plan.

One of the biggest barriers remained access to social care. Recognising that further delay would simply lead to another failed discharge, the team arranged for a Care Act assessment to be completed immediately from his hospital bedside, facilitating the conversation directly with social services. The team's persistent advocacy changed the outcome. Following agreement of a comprehensive care plan, Gerry moved into a specialist residential care home where his medical, personal care and rehabilitation needs could finally be met.

Without sustained multidisciplinary advocacy, Gerry would almost certainly have continued the cycle of repeated emergency attendance, prolonged admission and discharge back to the street. Instead, he now has stable accommodation and the specialist care needed to support his long-term health.

Why this matters

The Hull team demonstrates that improving outcomes is not dependent on having every service available. Even without dedicated step-down accommodation, strong partnership working, specialist clinical advocacy and coordinated discharge planning can transform outcomes for patients while reducing avoidable pressure on hospitals.

Health Inclusion Pathway Plymouth (HIPP)

An integrated hospital and community team improving care for people with complex lives across Plymouth's health and housing system

By working seamlessly across hospital and community settings, the Plymouth Health Inclusion Pathway demonstrates how integrated multidisciplinary care improves patient outcomes, strengthens partnerships and reduces avoidable hospital use.

Established	2022
Coverage	Derriford Hospital, Mount Gould Hospital and community outreach across Plymouth
Commissioned by	Devon Integrated Care Board
Delivery partners	Livewell Southwest, University Hospitals Plymouth, Plymouth City Council, The Plymouth Alliance and local primary care

The challenge

Plymouth supports a relatively stable population of people experiencing homelessness and multiple disadvantage. Unlike many cities, the same individuals often return repeatedly to hospital if discharge arrangements fail, making the consequences of fragmented care highly visible.

Many patients experience combinations of:

- alcohol-related brain injury
- complex substance dependence
- severe mental ill health and dual diagnosis
- premature frailty
- social exclusion and long-term disengagement from healthcare.

As a naval city, Plymouth also supports a significant number of veterans, while continuing shortages of specialist housing, rehabilitation and step-down accommodation create additional challenges for safe discharge.

Impact in numbers April 2025 to March 2026

652 Referrals received

529 Comprehensive interventions

45 Brief interventions

The Response

The Health Inclusion Pathway Plymouth (HIPP) works wherever patients need support.

Within hospital, the team provides specialist in-reach across emergency departments, inpatient wards and discharge planning. Beyond hospital, the same multidisciplinary team delivers street outreach, drop-in sessions and regular clinics within hostels and community settings.

This integrated approach enables patients to receive consistent support throughout their recovery, rather than experiencing repeated handovers between disconnected services.

One of HIPP's greatest strengths is its genuinely multidisciplinary workforce. GPs, nurses, psychologists, occupational therapists, social workers and support staff work as a single team, linking statutory and voluntary services to address patients' physical health, mental health, housing and wider social needs together.

"Public health are big HIPP fans—but then again, show me someone who isn't. You're making a huge difference, and the system needs more people like you."

Former Public Health Specialist

"If I hadn't had the help, if I'm absolutely honest, I don't think I would be here now... I can never repay the help."

HIPP Patient

Referral sources:

- **46%** Inpatient wards
- **42%** Community settings
- **12%** Emergency departments

2025/26 Highlights

Embedding inclusion health within mainstream hospital services

During 2025/26, the team has worked to establish "Complex Lives" as a recognised service line within the hospital's operational structure, formalising the team's role and embedding inclusion health within the trust's systems. This embeds inclusion health within the hospital's core operating model, strengthening governance, accountability and long-term sustainability while ensuring patients with complex needs receive a consistent response across the organisation.

Securing long-term investment

Recognising a growing need for specialist drug liaison within hospital, the team piloted a new approach that successfully demonstrated its value. The evidence generated through this work secured recurrent joint funding from Public Health and the acute Trust, creating two dedicated drug liaison posts to work alongside HIPP.

Delivering truly integrated care

HIPP's GPs are employed within primary care while also holding hospital contracts. This innovative workforce model gives them prescribing rights and full access within the acute Trust, removing organisational barriers that often delay care and creating genuinely seamless working across healthcare settings.

Making every discharge count

Because Plymouth's homeless population is relatively stable, the same patients frequently return if discharge arrangements fail. The team uses this insight to influence clinical decision-making, helping hospital staff recognise that investing time in getting discharge right the first time reduces future admissions and improves long-term outcomes.

Strong partnerships despite limited resources

Although Plymouth has no dedicated step-down beds, HIPP achieves safe discharge through close collaboration with the Plymouth Alliance, Plymouth City Council and the Bournemouth Churches Housing Association hospital discharge team. Community clinics in hostels and day centres maintain relationships after discharge, helping patients remain engaged with healthcare while reducing avoidable crisis presentations.

Influencing the wider system

The success of the Plymouth model is now attracting attention. As Devon and Cornwall services continue to develop, neighbouring systems are looking to HIPP as a model for delivering integrated inclusion health services across the wider peninsula.

Teresa's story

Meeting people where they are can transform lives

Following the death of her husband, Teresa lost her home after a fire and relapsed into alcohol dependence.

By the time she was referred to the HIPP team, she had been sleeping rough for more than a year, drinking heavily and was no longer registered with a GP.

After several A&E attendances, the HIPP team first met Teresa at Derriford Hospital before continuing to engage with her during outreach sessions in Plymouth city centre. Recognising the impact of memory difficulties on her ability to engage with healthcare, they used flexible outreach, repeated contact and consistent relationship-building to earn her trust.

Psychologists, social workers, nurses, GPs, hospital clinicians and community partners worked together to develop a coordinated plan addressing both her health and wider social needs.

The journey was far from straightforward. Suitable housing was difficult to secure; safeguarding concerns were initially not acted upon and gaps in local services meant the team often provided support well beyond their formal remit.

Despite these challenges, the outcome was transformational. With sustained multidisciplinary support Teresa registered with a GP, accessed regular healthcare, received medication reviews, secured accommodation long enough to qualify for the local authority's main housing duty, gained social work support and accessed financial advocacy services.

The team's psychological assessment also helped ensure her memory difficulties were properly recognised during legal proceedings.

This case illustrates the power of persistent, person-centred care. By meeting the patient where she was - both literally and emotionally - the team helped her move from repeated crisis towards greater stability, improved health and a more secure future.

Why this matters

The Plymouth model demonstrates that integrated multidisciplinary teams achieve the greatest impact when they are not constrained by organisational boundaries. By working seamlessly across hospital, primary care and community settings, HIPP provides continuous support that improves patient outcomes, strengthens partnerships and helps prevent avoidable hospital admissions.

St George's Homelessness Inclusion Team

Preventing repeat crisis through early intervention in one of London's busiest Emergency Departments

By identifying vulnerable patients at their first point of contact with the hospital, the St George's team prevents repeated crisis presentations, strengthens partnership working and delivers safer, more coordinated discharge across South West London.

Established	2021 (relaunched October 2025)
Coverage	St George's University Hospitals NHS Foundation Trust and Queen Mary's Hospital, Roehampton
Commissioned by	South West London Integrated Care Board
Delivery partners	St George's NHS Trust, Wandsworth and Merton Councils

The challenge

As a major trauma centre and one of London's busiest emergency departments, St George's cares for large numbers of patients experiencing homelessness, severe social exclusion and complex health needs.

Many patients arrive with combinations of:

- severe mental ill health and substance dependence
- poorly controlled long-term conditions
- homelessness alongside pregnancy or caring responsibilities
- immigration-related barriers to housing and support
- language barriers that make navigating services particularly difficult.

Increasing pressure on housing, community mental health services and supported accommodation means many patients struggle to access help after leaving hospital, increasing the risk of repeated crisis presentations and avoidable admissions.

The team has also seen growing numbers of families with young children and pregnant women experiencing homelessness, alongside patients whose immigration status creates additional barriers to accessing housing and statutory support.

The Response

Based within the Emergency Department, the Homelessness Inclusion Team combines clinical expertise, housing knowledge and specialist serious violence leads.

Working across emergency care, inpatient wards and the community, the team identifies vulnerable patients at the earliest possible stage, coordinates safe discharge and continues supporting people long after they leave hospital.

This combination of early intervention and sustained follow-up helps prevent patients returning repeatedly to emergency care while strengthening links between healthcare, housing and community services.

> "On every occasion the team has reviewed the patient on day of referral despite a large caseload and gone above and beyond to advocate for these patients to support them with their health needs, financial issues and housing difficulties"
>
> **Partner in the Emergency Department and Acute Medical Unit**

> "Working closely with them in an MDT setting is a privilege. They are a huge asset to trust advocating and supporting the most vulnerable people in society."
>
> **Partner in the Emergency Department and Acute Medical Unit**

Impact in numbers October 2025 to March 2026

298 Referrals received

218 Comprehensive interventions

39 Brief interventions

2025/26 Highlights

Bringing housing into the hospital

After years of partnership working, Wandsworth Council embedded a dedicated housing officer within the team. Having housing expertise available on-site has transformed communication, accelerated decision-making and enabled complex housing issues to be resolved far more quickly during hospital admission. The model is now being extended through regular multi-agency working across neighbouring boroughs.

Creating a new response to serious violence

Analysis of local hospital data revealed that around 60% of patients admitted following violent incidents were over the age of 26 and therefore ineligible for existing youth violence services. Working with the Major Trauma Centre, the team successfully secured funding for two dedicated Serious Violence Leads, supporting patients who have been the victim of a violent incident or where there are safety concerns in the community. Since the SVT was launched in June 2025, the team has received 420 referrals in addition to the HIT case load.

The initiative has already been recognised nationally through nomination for an HSJ Patient Safety Award.

Preventing crisis through early intervention

Because the team is based within the Emergency Department, patients experiencing homelessness can be identified and supported at their very first contact with hospital. Those discharged directly from A&E receive follow-up calls and, where appropriate, ongoing casework to prevent future deterioration and avoidable readmission. This proactive approach enables intervention before problems escalate into repeated hospital attendance.

Supporting recovery beyond discharge

Patients continue receiving support for up to six weeks after discharge – and longer where necessary. This continuity helps people maintain accommodation, remain engaged with healthcare and avoid returning to crisis.

Influencing practice beyond individual patients

The team's expertise is increasingly recognised across the wider health system. During the year the clinical lead received the London Network of Nurses and Midwives "Ab Fab" Award, while the team presented its work in Parliament and contributed to the Wandsworth Director of Public Health's Annual Report.

These achievements reflect the team's growing influence on homelessness and inclusion health policy across southwest London.

Reggie's story

Looking beyond rent arrears to see the person behind the problem

Reggie arrived at St George's Emergency Department with severe breathlessness and swelling in his legs.

He was admitted with an infective exacerbation of chronic obstructive pulmonary disease, but this was only one part of a much bigger picture.

Over the previous two years he had attended the Emergency Department eight times. He was living with COPD, epilepsy, heart disease, previous brain injury, alcohol dependence and Wernicke–Korsakoff syndrome. He had also lost his accommodation after being evicted because of rent arrears.

When the Homelessness Inclusion Team became involved, the local authority initially concluded it no longer had a duty to assist because of those arrears. The team saw something different.

Using specialist clinical judgement and occupational therapy assessment, they recognised that Reggie's cognitive impairment meant he had been unable to manage his finances independently. This fundamentally changed the understanding of his situation. Rather than accepting the original decision, the team brought together healthcare professionals, occupational therapists and housing services through a series of multidisciplinary meetings.

Presenting clear medical evidence of both his cognitive impairment and wider care needs, they successfully challenged the local authority's decision. The outcome transformed his future.

Reggie was accepted into supported accommodation with an appropriate care package. A Care Act assessment secured ongoing social work support to help manage both his care and finances. The team also registered him with a new GP, supported his Universal Credit application and provided practical essentials including a mobile phone and clothing.

Without specialist multidisciplinary advocacy, Reggie would almost certainly have left hospital back into homelessness. Instead, he left with stable accommodation, coordinated healthcare and the long-term support needed to remain well.

Why this matters

The St George's team demonstrates the value of intervening early. By identifying vulnerable patients at the point of first presentation, coordinating multidisciplinary support and continuing care beyond discharge, the team prevents repeated crises before they become repeat admissions. For commissioners, it provides a practical example of how specialist inclusion health services can improve patient outcomes while reducing avoidable demand on urgent and emergency care.

2025/26 Needs Assessments and Consultancy: Case Studies

Building better services through Inclusion Health Needs Assessments

Pathway's Inclusion Health Needs Assessments give commissioners the evidence they need to understand local need, target investment effectively and develop services that improve outcomes while delivering better value.

Better evidence. Better decisions. Better services.

Case study

Doncaster

Turning evidence into action in just 12 weeks

Commissioned by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH

The challenge

Growing concern about unmet need highlighted the need for a clear understanding of homelessness and inclusion health across Doncaster.

Commissioners required a robust evidence base to support future investment decisions and identify priorities for service development.

The response

Working to an ambitious 12-week timetable, Pathway reviewed and synthesised a wide range of existing evidence, bringing together six local reports alongside routine health and service data into a single, coherent assessment.

Rather than creating new information, the project transformed fragmented intelligence into a practical resource that could support strategic decision-making.

The impact

- Delivered within 12 weeks, providing timely evidence to support commissioning decisions.
- Created a single evidence base by bringing together multiple reports and datasets.
- Informed future service development, with recommendations directly supporting the subsequent establishment of a new Pathway team.

Case study

West London

Helping partners target investment where it would have the greatest impact

Commissioned by West London Housing Partnership

The challenge

The West London Housing Partnership wanted a clearer understanding of homelessness across the sub-region to support future planning and strengthen delivery of local homelessness and rough sleeping strategies.

Given the complexity of the area – and the existence of established Pathway services in some boroughs – the challenge was identifying where additional evidence would add the greatest value.

The response

Working with local partners, Pathway combined strategic analysis with local intelligence to identify evidence gaps across West London.

Rather than duplicating existing work, the assessment recommended focusing detailed analysis on Hillingdon, where commissioners required the greatest additional insight.

The impact

- Targeted resources where evidence gaps were greatest, avoiding duplication of existing intelligence.
- Strengthened strategic planning, providing an evidence base for the West London Housing Partnership's future homelessness and rough sleeping work.
- Supported decision-making within one of England's most complex homelessness systems, including areas with high levels of rough sleeping and significant numbers of people accommodated through Home Office asylum support.

Why this matters

Effective services begin with a clear understanding of local need. Pathway's Inclusion Health Needs Assessments help commissioners move beyond assumptions by providing robust evidence that informs investment decisions, reduces commissioning risk and supports the development of services that deliver measurable improvements in patient outcomes and system performance.

Delivering change through specialist consultancy

As well as hospital teams and health assessments, Pathway delivered tailored consultancy in 2025/26, helping NHS organisations move from strategy to delivery, providing practical expertise that strengthens services, improves partnerships and supports sustainable system change.

Case study

Kent Sexual Health Services

Bringing the voices of underserved communities into commissioning

Commissioned by Kent County Council

The challenge

Kent County Council's 2024 Sexual Health Needs Assessment identified twelve underserved populations requiring greater attention.

While substantial evidence already existed, commissioners recognised an important gap: the experiences of people experiencing homelessness and the organisations supporting them were not sufficiently represented.

The Response

Working within the council's existing programme and governance arrangements, Pathway used its expertise in engaging inclusion health populations to reach people whose voices are often absent from traditional consultation processes.

Drawing on established relationships with homelessness services and voluntary organisations, the team gathered lived experience alongside frontline perspectives to strengthen the council's understanding of local need.

Importantly, the approach was adapted to fit Kent's existing methodologies, ensuring findings could be integrated seamlessly into the wider Sexual Health Needs Assessment.

The impact

- Delivered within a demanding programme timetable, ensuring findings informed key commissioning decisions.
- Strengthened the evidence base by bringing the experiences of people experiencing homelessness and frontline services into strategic planning.
- Worked within existing governance arrangements, allowing findings to be incorporated directly into the Council's final report.

Case study

Doncaster

Supporting a new specialist mental health service from concept to delivery

Commissioned by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)

The challenge

Following completion of Pathway's Inclusion Health Needs Assessment, RDaSH recognised the need for a specialist inclusion health team within its mental health services.

Having committed to developing the service, the Trust sought practical implementation support to translate recommendations into an operational model.

The Pathway approach

Based on experience working with other mental health trusts Pathway supported the Trust to design a service to fit alongside and enhance their wider provision.

Support included service design, implementation planning, workforce development and specialist training.

Recognising that successful services depend on strong partnerships, training was extended beyond the core Pathway team to include partner organisations working alongside the service.

The impact

- Established one of the first new Pathway teams within a mental health trust since the South London and Maudsley in 2015, demonstrating the flexibility of the Pathway approach.
- Turned strategic ambition into operational reality, helping RDaSH deliver its organisational commitment to reducing health inequalities.
- Developed a new performance framework, including quality measures and KPIs tailored to community mental health services.

Why this matters

Every health system is different. Pathway's consultancy supports commissioners and providers to adapt proven approaches to their own local context, ensuring new services are evidence-based, deliverable and designed to meet the needs of the populations they serve.

Whether supporting strategic planning, service redesign or implementation, the focus remains the same: improving patient outcomes while strengthening local health and care systems.

5. Partner with Pathway

"Whether you are looking to understand local need, redesign services or establish a specialist hospital team, Pathway provides practical support that improves outcomes, strengthens systems and delivers measurable value for the NHS."

Alex Bax, Pathway CEO

Helping NHS organisations improve care for people experiencing homelessness

As this report has demonstrated, people experiencing homelessness continue to experience some of the poorest health outcomes in England while placing disproportionate pressure on urgent and emergency care.

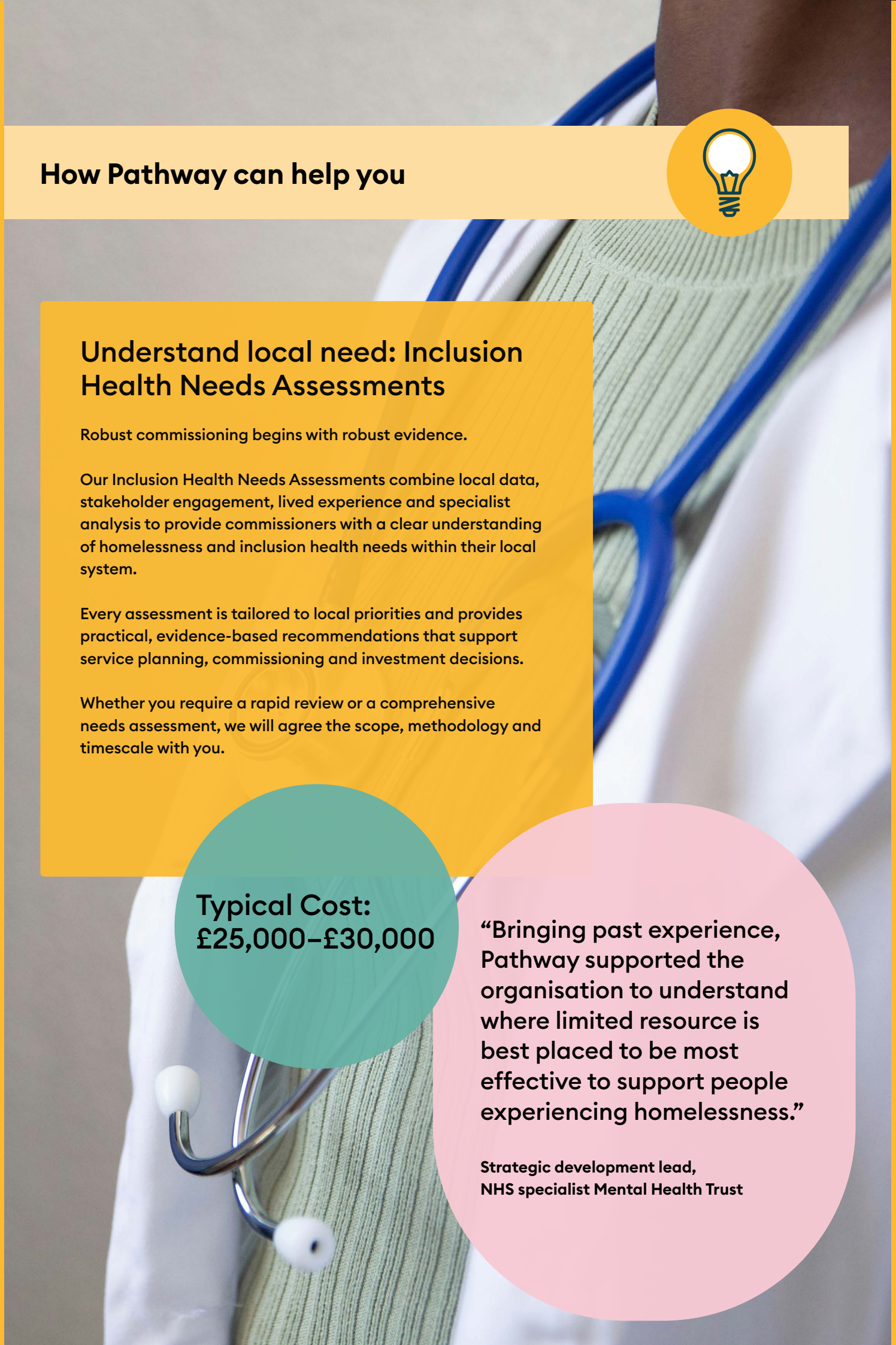
The evidence shows that specialist inclusion health services improve patient outcomes, reduce avoidable hospital use and deliver measurable value for commissioners.

Pathway is the UK's leading health and homelessness charity, working alongside NHS organisations to translate this evidence into practical action.

Through the Pathway Partnership Programme, we combine over 60 years of collective expertise in homelessness and inclusion health with practical implementation support that helps organisations deliver lasting improvement.

"Pathway is so close to the subject and the research. They know the latest evidence. They know what investment will bring return in benefits."

Commissioner, NHS ICB



How Pathway can help you

Understand local need: Inclusion Health Needs Assessments

Robust commissioning begins with robust evidence.

Our Inclusion Health Needs Assessments combine local data, stakeholder engagement, lived experience and specialist analysis to provide commissioners with a clear understanding of homelessness and inclusion health needs within their local system.

Every assessment is tailored to local priorities and provides practical, evidence-based recommendations that support service planning, commissioning and investment decisions.

Whether you require a rapid review or a comprehensive needs assessment, we will agree the scope, methodology and timescale with you.

Typical Cost: £25,000–£30,000

"Bringing past experience, Pathway supported the organisation to understand where limited resource is best placed to be most effective to support people experiencing homelessness."

Strategic development lead, NHS specialist Mental Health Trust

Design and improve services: Specialist consultancy and implementation support

Sometimes organisations need targeted expertise rather than a long-term programme.

We provide practical implementation support across a wide range of inclusion health challenges, including:

- service redesign
- workforce development
- stakeholder engagement
- community engagement
- business case development
- training and education
- pathway development
- programme implementation.

Every project is tailored to local needs and delivered alongside your existing teams.

Projects in 2025/26 have ranged in cost from £10,000 to £30,000

"The depth of specialist provision across disciplines is not possible to deliver locally."

Plymouth Team

Establish a Pathway Hospital Team

For organisations wishing to develop a specialist inclusion health service, there is no need to build a solution from the ground up. Pathway's proven model is ready to be rapidly implemented, drawing on years of development, testing and refinement, supported by significant investment from the Health Foundation. It provides a credible, scalable approach that can help Trusts deliver their agenda and improve outcomes in an increasingly challenging environment.

We provide comprehensive implementation support from initial design through to long-term sustainability. This includes help to:

- develop the service model
- recruit the right team
- provide specialist training
- establish governance and quality systems
- measure outcomes
- build sustainable partnerships
- join the national Pathway Partnership Programme network.

Partnership support

Phase	Duration	Supports	Typical investment
Phase 1	12 months	Service design, recruitment, implementation, training and launch support	£35,000
Phase 2	24 months	Ongoing quality improvement, data analysis, peer support and sustainability	£23,000

> "The knowledge and support you provide is invaluable."
>
> **St George's Homelessness Inclusion Team**

During the programme, teams receive:

- specialist implementation support
- performance data and annual impact reporting
- secure access to Pathway's online comprehensive operational manual
- Faculty for Homeless and Inclusion Health resources
- national peer learning events
- specialist masterclasses and annual conference
- regular support visits from the Pathway Partnership team.

Why organisations choose Pathway

Organisations partner with Pathway because we combine national expertise with practical experience.

We do not simply produce recommendations - we work alongside NHS organisations to implement change, strengthen partnerships and demonstrate measurable impact.

Whether supporting a single project or helping establish a new specialist service, our focus remains the same:

- improving patient outcomes
- reducing health inequalities
- strengthening local systems
- delivering better value for the NHS.

Dr Chris Sargeant,

Medical Director & Clinical Lead, Pathway Partnership Programme

Start the conversation

If you would like to discuss how Pathway can help your organisation improve outcomes for people experiencing homelessness and address inclusion health needs, we'd be delighted to talk.

Paul Hamlin
Pathway Partnership Programme

paul.hamlin@pathway.org.uk

Dr Chris Sargeant
Medical Director and Clinical Lead, Pathway Partnership Programme

chris.sargeant@pathway.org.uk

Appendix 1
Teams on the Pathway Partnership Programme 2025/26

Cardiff

In-Reach Team Leads:
Dr Ayla Cosh, GP & Clinical Director CAVHIS / Dr Carwyn Shires, GP & Clinical Lead for the In-Reach team / Geraldine Jones, Lead Nurse Practitioner (In-Reach) / Josie Collins, Senior Nurse.

Wider CAVHIS Team:
GPs: Dr Heledd Jones, Assistant Director CAVHIS / Dr Ellie Harris / Dr Elle Morgan / Dr Rebecca Cox
Lead Nurse Practitioners: Catherine Castle / Jayne Barrett / Kelly John.

Admin: Andrew Jones, Operational Manager / Rebeca Short, Departmental Operational Manager

East Kent

Millie Waters, Homeless Health Nurse / Helen Burnett, Homeless Health GP / Lorraine Seago, Porchlight, Homeless Health Coordinator and outreach support / Nicola Rees, Canterbury City Council, Homeless Health Housing Officer / Karen Nicholson, Homeless Health administrator

Hackney

Mary-Jane Bertin, Nurse and Team Lead / Laura Jacobs, Occupational Therapist / Theresa Murphy De Souza, GP and Clinical Lead / Javaize Fenton, Hackney Housing Worker / Maxwell Richardson, Providence Row, Community Link Worker / Eleanor Watson, Providence Row, Community Link Worker

Hull Team

Helen Thompson, Head of Operations / Emma Nicholson, Team Manager / Dr Jenifer De La Cruz, GP / Anna Darwick, Lead Nurse / Michelle Cochrane-Booth, Nurse / Briony Sergison , Care Navigator

Plymouth

Ben Jameson, Clinical Lead & GP / Danny Fay, GP / Darren Lloyd, Operational Lead & Mental Health Nurse / Charlotte Mayow, Social Worker / Kat Byrne, Physical Health Nurse / Sally Sheridan, Occupational Therapist / Simone Steadman, Clinical Psychologist / Jenna Hayward, Healthcare Assistant / Rebecca Griffiths, Support Worker / Rosina Russell, Team Administrator

St George's

Chloe Bell, Nurse & Team Lead / Danielle Williams, GP & Clinical Lead / Sally Bartolo, Serious Violence Lead / Jamie Robinson, Serious Violence Housing Lead / Rosie Andrassy, Homelessness Housing Navigator / Rhian Clugston, Homelessness Housing Navigator / Juliette Gosling, Homelessness Inclusion Care Navigator / Annabelle Ade-Jones, Homelessness Housing Navigator / Gemma Casey, ED Manager / Yusuf Warsame, Wandsworth Homelessness Prevention and Solutions Officer

Appendix II
Partnership Hospital Team Data 2025–2026

Introduction

Pathway Partnership teams collect and submit a standardised dataset, providing a consistent picture of who teams are supporting, the complexity of their needs and the difference teams make. The data enables Pathway and its partners to:

- understand the number and characteristics of people supported by Pathway teams;
- monitor key quality indicators and support local quality improvement;
- demonstrate the activity, outcomes and impact of teams;
- identify opportunities for quality improvement across the Partnership Programme; and
- inform Pathway's wider policy, campaigning and work to influence health and care systems.

Behind these figures is a substantial amount of work by teams; both in delivering care and support to patients and in recording the information needed to understand and improve that work.

The data in this appendix covers the period 1 April 2025 to 31 March 2026.

Key findings from 2025/26

1,817 patient referrals were accepted: 1,461 received full intervention and 356 brief intervention.

Patient demographics remained broadly consistent with previous years, including a male-to-female ratio of approximately 3:1.

4.4% of patients had No Recourse to Public Funds (NRPF), falling from 12% in the previous year. The proportion remained higher among London teams, at 10.1%.

A note on the data: One team was unable to submit patient-level data to Pathway; one service was paused for six months, and another submitted full data for Q3 and Q4 only, with referral numbers supplied for Q1 and Q2. These differences should be considered when interpreting programme-wide figures.

2025/26 patient referrals

Referral	Total	Average per team (5 teams)	Average per team member (32.5)	% of total
Accepted intervention	461	292	45	69%
Accepted brief intervention	356	71	11	17%
Rejected	313	63	10	15%
Total	**2,130**	**426**	**66**	**100%**

Patient numbers

To give a clearer picture of the support teams provide, accepted referrals are divided into two categories:

Full intervention: Most patients receive a full intervention, including a holistic assessment, personalised care plan and targeted clinical, housing and social support.

Brief intervention: Sometimes full intervention is not possible. This may be because a patient self-discharges, is only in A&E for a short period, or because of limitations in team capacity. Teams will nevertheless provide as much support as possible, including advice, referrals and signposting, or advice to hospital colleagues and external partners.

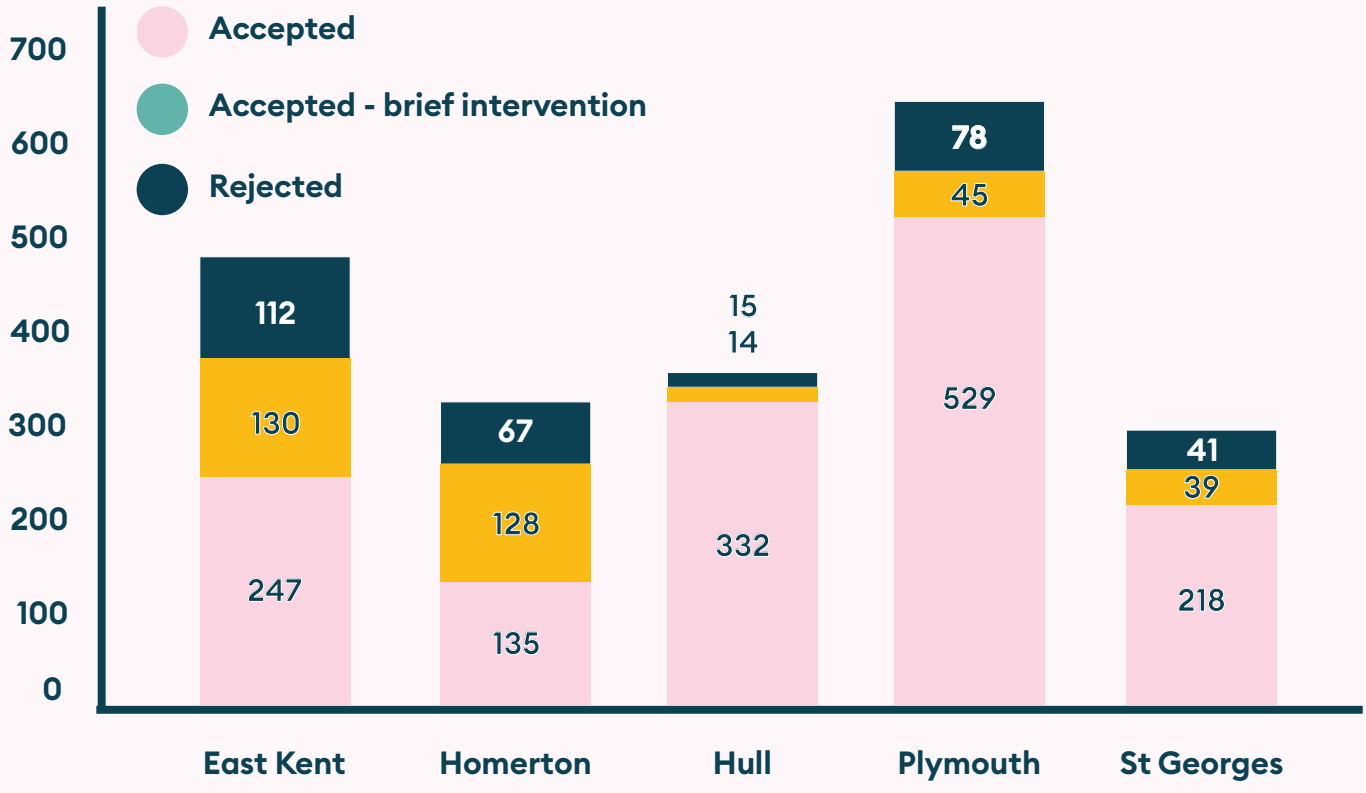
Separating these two types of intervention gives a more accurate picture of activity, outcomes and quality. A brief intervention does not necessarily mean limited impact. Teams with community outreach or greater capacity for follow-up can use these initial contacts to build relationships, develop care plans, connect people with other services and safeguard vulnerable patients.

Direct comparisons between teams should be made with care. Caseloads are affected by factors including team size and skill mix, local patient demographics, the number and location of hospital sites covered, whether teams also work in community settings and how long they can continue supporting patients following discharge.

Note: St George's HIT figures represent six months of activity because the service was paused for six months before relaunching in October 2025.

The Cardiff CAVHIS In-Reach team was unable to provide comparable data and reports its outcomes separately at local level.

Referrals per team



Patient characteristics

The demographic profile of patients remained broadly consistent with previous years.

There continued to be approximately three male patients for every female patient. There was a small increase in the proportion of people aged 56–65 and 65+, and a slight reduction in the 36–45 age group. The average age of patients supported in 2025/26 was 46, one year older than in the previous year.

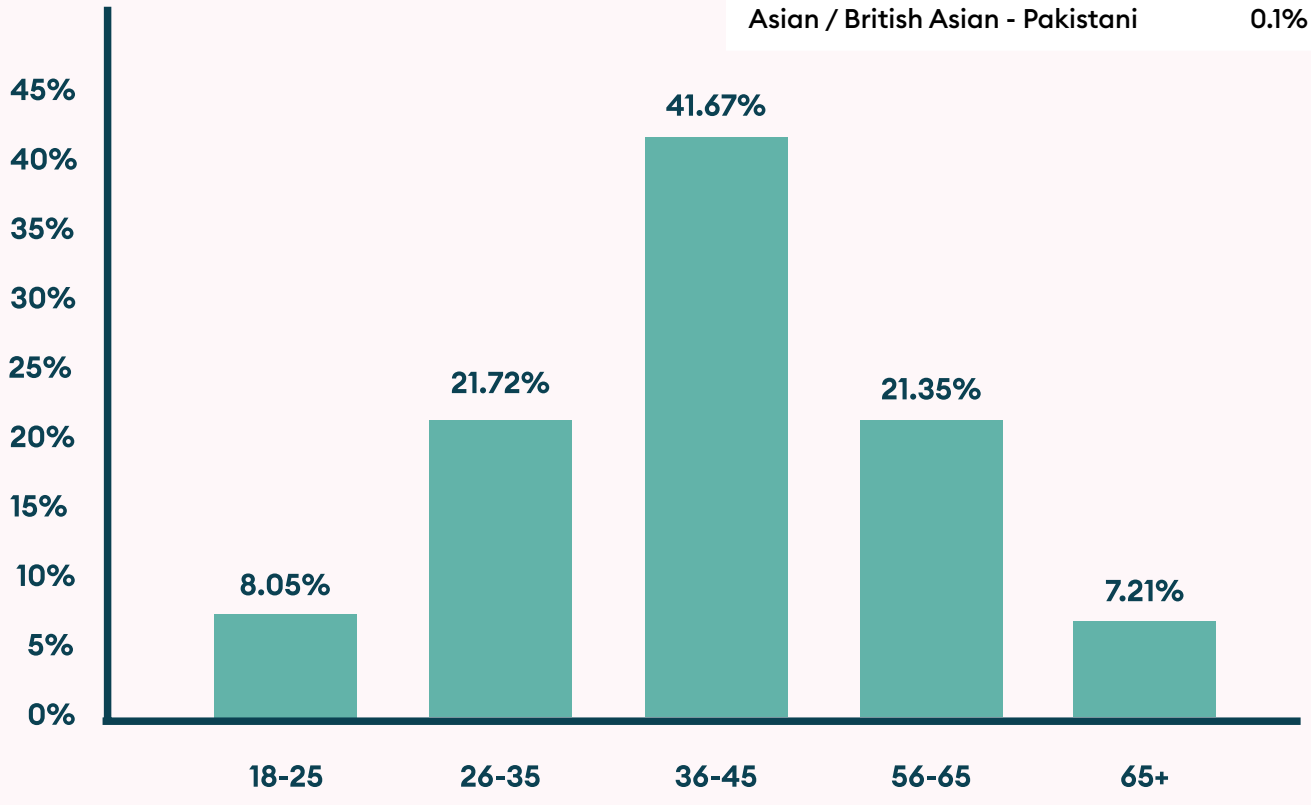
Ethnicity data was also broadly consistent with previous years. White British, White Other, Other and Black/Black British remained the four most recorded ethnic groups among accepted referrals.

There was a notable reduction in the proportion of patients recorded as having No Recourse to Public Funds (NRPF). Overall, this fell from 12% to 4.4%. Among London teams, it fell from 18.9% to 10.1%.

Patient ethnicity

Ethnicity	%
White - British	56%
No Data	21.6%
White - other	7.8%
Black / Black British - Carribean	3.6%
Other	2.4%
Black / Black British - African	2.1%
Asian / Black British - Other	1.8%
Mixed	1.8%
Black / Black British - Other	1.3%
White - Irish	0.6%
Gypsy / Roman / Irish Traveller	0.3%
Arab	0.3%
Asian / British Asian - Indian	0.2%
Asian / British Asian	0.1%
Asian / British Asian - Chinese	0.1%
Asian / British Asian - Pakistani	0.1%

Patient age group



Increasing levels of patient need

The data confirms what teams have been reporting from their frontline work: the people they are supporting are presenting with increasingly complex combinations of clinical and social need. Safeguarding needs, care needs and concerns relating to cognition and capacity also remained high.

These figures underline the challenge facing both Pathway teams and the wider NHS. People experiencing homelessness are frequently arriving in hospital with multiple, overlapping needs that cannot be addressed through treatment of a single condition alone. Effective care requires the clinical, housing and social needs of the individual to be understood and addressed together.

Patient needs

Patient need	2022/23	2023/24	2024/25	2025/26
Mental health	55%	60%	56%	75%
Substance misuse	55%	62%	66%	86%
Dual diagnosis	-	38%	44%	70%
Safeguarding	42%	35%	46%	46%
Care needs	40%	20%	19%	21%
HIU	Not recorded	Not recorded	Not recorded	37%
Mobility / accessibility	32%	30%	29%	40%
Cognition / capacity	22%	15%	16%	17%

Appendix III
Quality Improvement in 2025/26

Measuring and improving quality

Pathway Partnership Programme teams record activity and outcomes against Pathway's Quality Framework.

The framework provides a consistent set of quality indicators covering different aspects of patient care and wider inclusion health outcomes. Routine monitoring allows teams, supported by Pathway, to identify where improvement is needed, make changes, and measure progress.

The Quality Framework was developed by Pathway's expert team in collaboration with people with lived experience and teams across the Partnership Programme. The headline figures can appear simple, but the work behind them is often complex. Improving a single indicator can require sustained clinical work, advocacy and coordination across hospital departments, local authorities, primary care, housing and voluntary sector services.

Overview

The 2025/26 data show Pathway Partnership teams continuing to deliver high-quality care and achieve positive outcomes for patients experiencing homelessness.

This has been achieved in an increasingly difficult operating environment. Hospitals continue to face high demand and limited capacity, while Pathway teams report increasing levels of complexity among the people they support. Nearly all teams have also faced uncertainty over future funding, with some already operating with fewer staff following funding reductions.

Against this backdrop, teams have continued to support large numbers of people while maintaining high standards of care.

Performance against key quality indicators

Outcome	2023/24	2024/25	2025/26
GP registration completed	46%	70%	79%
Rough sleeping reduction	42%	66%	57%
Housing advocacy completed	80%	83%	75%
Holistic assessments completed	85%	90%	94%
Care plans completed	82%	82%	96%
Self-discharge rate	14.1%	12.3%	18%
Delayed discharge rate	16.8%	11.9%	11.4%
Assessment within two days	97%	98%	83%

Quality Indicator 1: GP registration

Access to a GP is fundamental to ensuring that patients can continue to receive healthcare after leaving hospital. Without appropriate access to primary care, people experiencing homelessness struggle to obtain treatment and ongoing support in the community, undermining their recovery and increasing the risk of returning to hospital.

2025/26 outcome:
Teams registered 79% of patients who needed one with a new GP before they left hospital.

Quality Indicator 2: Housing advocacy

Clinically led housing advocacy is an important part of achieving a safe and sustainable discharge for people experiencing homelessness.

Pathway teams undertake a range of housing advocacy, including statutory Duty to Refer referrals, connecting patients with VCSE organisations and making referrals to supported housing, care homes and other supported living arrangements.

2025/26 outcome:
Housing advocacy information was recorded for 1,144 referrals. Of these, 75% received some form of housing advocacy.

Quality Indicator 3: Housing outcomes

Housing status is not routinely recorded across NHS settings. Pathway teams therefore record patients' housing status when they enter hospital and again when they leave.

This provides important evidence about the impact of housing advocacy and care coordination on discharge outcomes. Across the Partnership Programme, it also helps build a clearer picture of the housing circumstances of people experiencing homelessness who are using hospital services.

2025/26 outcomes:
57% of patients who were rough sleeping on admission were no longer rough sleeping when they left hospital. Among patients who were sofa surfing on admission, 64% were no longer sofa surfing on discharge.

These figures demonstrate that hospital admission can provide an important opportunity not only to address immediate health needs, but to intervene in the wider circumstances contributing to poor health and repeated use of hospital services.

Quality Indicator 4: Holistic assessments and care plans

Improving the quality and coordination of care that people experiencing homelessness receive in hospital is at the heart of the Pathway approach.

Holistic assessment enables teams to look beyond a patient's immediate reason for attending hospital and identify the wider health, housing and social needs that may affect their recovery and ability to remain well following discharge. A care plan then provides a basis for coordinating the response to those needs.

Performance in 2025/26 was particularly strong, despite the increasing complexity of patient need and the pressures facing hospital services.

2025/26 outcomes: 94% of patients had a holistic assessment completed and 95.5% had a care plan recorded.

Quality Indicator 5: Self-discharge

Self-discharge can make it harder to complete treatment and put appropriate support in place before a patient leaves hospital.

People experiencing homelessness may face barriers to remaining in hospital and engaging with care, making this an important indicator for Pathway teams.

2025/26 outcome:
18% of accepted patient referrals were recorded as self-discharges, compared with a 4% rate stated for the general population.

Quality Indicator 6: Delayed discharge

For people experiencing homelessness, leaving hospital safely can depend on services and support well beyond the hospital itself.

The main reasons recorded for delayed discharge in 2025/26 included difficulties finding appropriate placements for people with complex needs, challenges affecting people with No Recourse to Public Funds and delays in local authorities securing suitable housing.

2025/26 outcome:
11.4% of accepted referrals had a delayed discharge recorded, a small improvement on 11.9% in 2024/25 and substantially below the 16.8% recorded in 2023/24.

Quality Indicator 7: Time from referral to assessment

Pathway Partnership teams have a target to assess at least 80% of patients within two working days of referral.

Early assessment matters. The sooner a team meets a patient, the more time it has to build trust, understand their needs, advocate on their behalf, and work with hospital and community partners to put comprehensive care and discharge arrangements in place.

This helps teams make the most of the opportunity presented by a hospital admission and begin planning for a safe discharge as early as possible.

2025/26 outcome:
83% of patients for whom both a referral and assessment date were recorded were assessed within two working days, exceeding the programme target of 80%

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